# WV MEDICAID PRIOR AUTHORIZATION FORM

**Today's Date** _____ **FAX 1.844-633-8426 INPATIENT**

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON HTTPS://PROVIDERPORTAL.KEPRO.COM

**C3 Requesting/Submitting Organization** _____ Please list exactly as registered on C3

**Address, City, State, Zip** _____

**C3 Requesting/Submitting Organization NPI** _____ Please list exactly as registered on C3

**Person Submitting Request** _____ **Phone** _____ **Fax** _____ **Email**_____

## Referring/Ordering Provider

(Per policy the Referring/Ordering Provider must be actively enrolled with WV Medicaid)

| | | |
|---|---|---|
| **Name** Do not write "See Above" | **NPI Number** | |
| **Contact Information** | **Phone** | **Fax:** |

## Place of Service/Servicing Provider

(Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

| | |
|---|---|
| **Name** Do not write "See Above" | **NPI Number** |
| **Address, City, State, Zip** | |

**Member Medicaid Number** _____ **DOB**_____

1 **Member First Name** _____ **Last Name** _____

**Procedure Type:** ☐Elective ☐General/Acute ☐Organ Transplant **Place of Service: INPATIENT HOSPITAL WV001**

**ADMISSION DATE:** **DISCHARGE DATE:**

**List Other Retro Reason:**

**Authorization Type:**

☐**Prior Authorization**

☐**Retrospective Request, if applicable list the appropriate reason:**

☐**Denied by Member's Primary Payer** ☐**Retrospective Medicaid Eligibility**

**For Members under age 21, is this request an EPSDT referral?** ☐**Yes** ☐**NO** **If yes, please submit the most current EPSDT form on file**

***The WV Bureau for Medical Services defines MEDICALLY URGENT as follows: A delay in services could seriously jeopardize 1. the life or health of the consumer; 2. the ability of the consumer to regain function; 3. in the opinion of a physician with knowledge of the consumer's condition, would subject the consumer to severe pain that cannot be adequately managed without care or treatment that is the subject of the case.***

**Type of Admission**

☐Direct ☐Direct/Medically Urgent ☐Elective ☐Elective/Medically Urgent ☐Emergency
☐Non-Elective ☐Non-Elective/Medically Urgent ☐Transplant ☐Transplant/Medically Urgent ☐Emergency/Medically Urgent

**Type of Unit**

☐Coronary Care Unit ☐Medical/Surgical ☐Critical Care Unit ☐Neonatal Intensive Care Unit (NICU)
☐Intensive Care Unit (ICU) ☐Special Care Nursery ☐Intermediate Care ☐Telemetry ☐Other: _____

Does this admission follow observation? ☐Yes ☐No If yes, Date of Observation _____

**If Yes, describe the progression of symptoms/illness plus treatment administered during observation:**

## List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX:

**SERVICES REQUESTED:**

1. **CPT CODE:** _____ **Description:** _____
2. **CPT CODE:** _____ **Description:** _____
3. **CPT CODE:** _____ **Description:** _____

**Is this a Bariatric** ☐**Yes**☐**No** ***For Panniculectomy CPT 15830 Procedures Weight Loss Ranges:*** ☐0-25 ☐26-50☐51-75 ☐76-100 ☐100-125 ☐125+

**Is this a Breast Reduction?** ☐**Yes** ☐**No** **If yes, please list current bra size**_____

**Is this an Orthopedic Procedure?** ☐**Yes** ☐**No**

If yes, have NSAIDS been tried? ☐**Yes** ☐**No** *If yes mark duration:* ☐0-3 months ☐3-6 months ☐6-9 months ☐12+ months ☐9-12 month

*If yes list outcome, if no list why:*

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If yes, has activity modification been tried? ☐Yes ☐No *If yes mark duration:* ☐0-3 months ☐3-6 months ☐6-9 months ☐12+ months ☐9-12 month

*If yes list outcome, if no list why:*

**PLEASE INDICATE/INCORPORATE ALL ASSOCIATED TREATMENTS, THERAPIES, PREVIOUS DIAGNOSTIC STUDIES, ETC., (TO INCLUDE THE RELATION, DURATION, OUTCOMES, ACTIVITY MODIFICATIONS):**

# FOR ORGAN TRANSPLANT ONLY

☐**Heart Transplant** ☐**Adult Liver** ☐**Bone Marrow** ☐**Pediatric Liver**

☐**Kidney** ☐**Left** ☐**Right**

☐**Pancreas/Kidney** ☐**Left** ☐**Right**

☐**Lung** ☐**Single** ☐**Double** ☐**Left** ☐**Right**

☐**Heart/Lung** ☐**Single** ☐**Double** ☐**Left** ☐**Right**

☐**Small Intestine**

☐**Cornea** ☐**Left** ☐**Right**

**Is a second organ being transplanted?** ☐**Yes** ☐**No** ***If YES, please select reason:***

☐**Primary organ defect caused damaged to a second organ and transplant of the primary organ will eliminate the disease**

☐**Damage to the second organ will compromise the outcome of the transplant of the primary organ**

**Additional Notes for Organ Transplant :**

**Please Note: If supporting documentation will be sent by mail or fax, please send the H&P, labs, imaging and treatment pertinent to the current admission ONLY. Sending the patient's entire medical record can cause delays in the processing of your request.**