



# WVCHIP PRIOR AUTHORIZATION FORM

## FAX 1-844-633-8429 DME

Today's Date \_\_\_\_\_

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

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Contact Information</b>	<b>Phone</b>	<b>Fax:</b>

Place of Service/Service Provider \_\_\_\_\_ (Per policy the Place of Service/Service Provider must be actively enrolled with WVCHIP)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Address, City, State, Zip</b>		

Member WVCHIP Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Member Address, City, State, ZIP \_\_\_\_\_

Procedure Type: DME Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent

Authorization Type: Prior Authorization Retrospective WVCHIP Eligibility

Retrospective Request, when applicable list the appropriate reason:

Request Type: New Repair Replacement

Length of Time Needed: Days Months Ongoing Permanent Weeks Years

Does member have an Individual Education Plan(IEP) that includes these services? Yes No \*If yes, please attach a copy.

### DOCUMENTS TO BE SUBMITTED:

- |  |                      |     |    |     |
|--|----------------------|-----|----|-----|
| • Certificate of Medical Necessity       | Date of CMN _____    | Yes | No |     |
| • Signed Physician's Order(s)            | Date of Order _____  | Yes | No |     |
| • Most Recent Progress Notes             | Date of Notes _____  | Yes | No | N/A |
| • Waiver Letter for School-Aged Children | Date of Letter _____ | Yes | No | N/A |
| • Treatment Care Plan                    | Date of TCP _____    | Yes | No | N/A |
| • Members Individual Education Plan      | Date of IEP _____    | Yes | No | N/A |
| • OTHER DOCUMENTS ATTACHED _____         |                      |     |    |     |

<b>START DATE</b>
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\*\*I certify that this patient meets the program eligibility criteria and that this equipment is a part of the course of treatment and is reasonable, medically necessary and is most cost effective and is not a convenience item for the recipient, family, attending practitioner or supplier. To my knowledge, the information included on this application is accurate. Yes No

LIST DME CPT/HCPC:

MAKE A COPY OF THIS PAGE FOR MULTIPLE CPT/HCPC CODES AND SUBMIT A PAGE PER

CPT/HCPC-Quantity Ordered

Frequency of Use

ICD DX Code(s)

Symptoms:

Date of Anticipated Equipment Replacement

DME Vendor Cost Quote \$

ATTACH Cost Invoice/Calculation

Clinical Indications for Items Requested—Mark all Applicable

Medical Equipment

General Medical Equipment

Other Medical Equipment: \_\_\_\_\_

Enteral Nutrition, If Yes-Enteral Feedings Product \_\_\_\_\_ Enteral Feedings Frequency \_\_\_\_\_

PLEASE CIRCLE ALL APPLICABLE CRITERIA BELOW FOR ENTERAL NUTRITION:

- a) Permanent Impairment > 90 days from onset
- b) Caloric Intake > 50% Daily
- c) Impaired digestion, malabsorption or nutritional risk as indicated in anthropometric measures
- d) Weight loss for adults showing: Involuntary or acute weight loss greater than or equal to 10% of usual body weight during a 3-6 month period or BMI below 18.5 kg/m2.
- e) Weight loss for neonates, infants and children showing: Very low birth weight(LBW)even in the absence of gastrointestinal, pulmonary or cardiac disorders. Lack of weight gain or weight gain less than 2 standard deviations below the age appropriate mean in a 1 month period for children under 6 months or in a 2 month period for children 6-12 months. No weight gain or abnormally slow rate of gain for 3 months for children older than 1 year or documented weight loss does not reverse promptly with instruction in appropriate diet for age. Weight for height less than the 10th percentile.
- f) Abnormal laboratory test pertinent to the diagnosis
- g) Anatomic structure of the gastrointestinal tract that impairs digestion and absorption
- h) Diagnosis of inborn errors or metabolism that require food products modified low in protein
- i) Failure to Thrive(FTT) diagnosis that increases caloric need while impairing caloric intake and/or retention
- j) Increased metabolic and/or caloric needs due to excessive burns, infection, trauma, prolonged fever, hyperthyroidism or illnesses that impair caloric intake and/or retention
- k) Neurological disorders that impair chewing or swallowing
- l) Prolonged nutrient losses due to malabsorption syndromes or short bowel syndrome, diabetes, celiac disease, chronic pancreatitis, renal dialysis, draining abscess or wounds
- m) Treatments with anti-nutrient or catabolic properties

Feeding Tube

IV Infusion Therapy

Mobility and Bathroom Safety Aids

Bathroom Safety Aids

LIST Other Mobility Aids: \_\_\_\_\_

Wheelchair: *Manual* *Power* (Be sure to Complete Page 3)

Medical Supplies

Ostomy Supplies

Incontinence Supplies, CIRCLE reason below:

- a) Patient has a congenital urinary tract abnormality causing incontinence
- b) Patient has a neuromuscular defect causing incontinence
- c) Patient has a developmental delay with urogenital sequelae
- d) Other clinical evidence to support incontinence or inability to toilet train

Respiratory Equipment

BiPAP

CPAP

Nebulizer

Respiratory Equip-Ventilator

Oxygen(O2)

- Oxygen Liters or % of O2 Administered: \_\_\_\_\_ Oxygen Saturation: \_\_\_\_\_

Respiratory Equip-Breathing Treatment

- Breathing Treatment-Medication Administered \_\_\_\_\_ Breathing Treatment-Frequency \_\_\_\_\_

Infant Apnea Monitors

- a) Birth Weight \_\_\_\_\_ Gestational Age(in weeks) \_\_\_\_\_
- b) Sibling of SIDS  Yes  No
- c) Infant with Narcotic Addict Mother  Yes  No
- d) Infant with High-Risk Cardiac Disease  Yes  No
- e) Infant with Tracheostomy  Yes  No
- f) Prematurity  Yes  No
- g) Parent/Guardian Certification (Attached  Yes  No )
- h) Apnea Delay Rate(in seconds) \_\_\_\_\_
- i) Apparent Life Threatening Event(ALTE)  Yes  No If Yes, complete below and attach all relevant ALTE documentation. Date of ALTE \_\_\_\_\_  
 Number of ALTE Episodes \_\_\_\_\_ ALTE Hospital Name \_\_\_\_\_  
 ALTE Hospital Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_ Follow-up appointment date: \_\_\_\_\_

Other: \_\_\_\_\_

# ANSWER ALL QUESTIONS FOR A WHEELCHAIR REQUEST

Is there a current placement?  Yes  No

Date of Environmental Assessment \_\_\_\_\_

If Yes, Type of Equipment: \_\_\_\_\_

Other Equipment Utilized Effectively: \_\_\_\_\_

How far can the person ambulate unassisted?  >150 feet  0-50 feet  51-100 Feet  101-150 feet

Member is expected to grow in height  Member may increase in weight/width up to 5 inches

Member requires special developmental capability  Member weighs less than 125 pounds

Member may require a seat-to-back angle range of adjustment in excess of 12 degrees

Is there a current placement	Yes	No
How far can the person ambulate unassisted?	>150 feet	101-150 feet
	0-50 feet	51-100 Feet
Is this equipment modifiable to meet the member's future needs?	Yes	No
An environmental and functional assessment has been completed to determine that the equipment recommended based on the Physician's order is the most appropriate and cost effective to meet the member's basic health care needs?	Yes	No
Is wheelchair warranty in place for at least one year?	Yes	No
Can repairs be safely made to the current equipment?	Yes	No
If answer to questions 3-6 above is NO, please provider explanation here		
How was it determined that the wheelchair selected can be utilized effectively in the member's current environment?	Home/Site Visit Member of Caregiver Report	Equipment Utilized Effectively-Other Other:
Length of time member will use wheelchair daily	<2 hrs per day 2-8 Hrs per day	9-12 Hrs per day >12 hrs per day
The member will use the wheelchair primarily/routinely	Both inside and outside of the home Indoors on smooth hard surfaces	Outside on rough, unpaved, uneven surface Outside on smooth paved surfaces
The Member will encounter obstacles	<=.75 inches <.75 inches-<=1.5 inches	>1.5 inches-<=2.5 inches >2.5 inches
The Member has a documented medical need for a feature not routinely available on a lower level Power Wheelchair(PWC)	Yes	No
If Yes, Describe the required feature and the environment in which the PWC will be used and the routine performance of ADLS		
The Members requires a drive control interface other than hand or chin operated standard proportional joystick	Yes	No
If Yes, Control-Interface Explanation		
The member has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair and/or the member uses a ventilator that is mounted on the wheelchair	Yes	No
If Yes, Power tilt and recline seating explanation plus describe the ADLs that will be possible with the additional feature that would not be possible with the additional feature:		