



WVCHIP PRIOR AUTHORIZATION FORM

FAX 1-844-633-8430 HOME HEALTH

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)

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

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

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

Member WVCHIP Number _____ DOB _____

Member First Name _____ Last Name _____

Procedure Type: Home Health Patient Status: Initial Established

Authorization Type: Prior Authorization Retrospective WVCHIP Eligibility
 Retrospective Request, if applicable list the appropriate reason:

List Other Retro Reason:

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

Place of Service: Homeless Shelter Home Assisted Living Group Home

If Member is under age 18, are they enrolled in the Children with Special Health Care Needs Program? Yes No

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX: _____

SERVICES REQUESTED

<input type="checkbox"/> Physical Therapy	Units :	Planned Number of Visits:	Service Start Date:
<input type="checkbox"/> Occupational Therapy	Units :	Planned Number of Visits:	Service Start Date:
<input type="checkbox"/> Speech/Language Therapy	Units :	Planned Number of Visits:	Service Start Date:
<input type="checkbox"/> Skilled Nursing Visit(s)	Units :	Planned Number of Visits:	Service Start Date:
<input type="checkbox"/> Medical Social Works Services	Units :	Planned Number of Visits:	Service Start Date:
<input type="checkbox"/> Home Health Aide Services	Units :	Planned Number of Visits:	Service Start Date:

*****Please complete the following if request if for an ESTABLISHED patient. *****

Patient's Current Condition: Acute Chronic Long-Term Long-Term Maintenance (condition is stable) Terminal

Medical Necessity: **You may attach H&P or other relevant clinical documentation—if so, please write see attached**

Planned Interventions (Including Frequency):

Mental Status:

Caregiver Support Available: Yes No

If yes, Caregiver is available/willing to receive education necessary to provide services to the member? Yes No

If No, explain

Ventilator Dependent: Yes No Ventilator Hours per Day _____

Please answer the following questions regarding current treatment:

Intravenous Fluids/Medications: Yes No If Yes, Type _____ Dose _____ Duration _____ Frequency _____

Enteral (Tube) Feedings: Yes No If, yes is this the sole source of nutrition? Yes No If yes, Type of Nutrition _____ Frequency _____

Oxygen: Yes No If yes, LPM _____ Hours per Day _____

Non-Ventilator Dependent Tracheostomy: Yes No

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