



WVCHIP 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](https://PROVIDERPORTAL.KEPRO.COM)

C3 Requesting/Submmitting Organization _____ Please list exactly as registered on C3

Address, City, State, Zip _____

C3 Requesting/Submmitting 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/Serviceing Provider _____ (Per policy the Place of Service/Serviceing 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: Elective General/Acute Organ Transplant **Place of Service: INPATIENT HOSPITAL WV001**

| | |
|------------------------|------------------------|
| ADMISSION DATE: | DISCHARGE DATE: |
|------------------------|------------------------|

| |
|---------------------------------|
| List Other Retro Reason: |
|---------------------------------|

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

WVCHIP 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:

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.