



# WVCHIP PRIOR AUTHORIZATION FORM

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

**FAX 1.844-633-8426 INPATIENT REHAB**

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 \_\_\_\_\_

Registered 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 \_\_\_\_\_

Procedure Type: INPATIENT REHAB WV002 Place of Service: INPATIENT HOSPITAL

List Other Retro Reason:

ADMISSION DATE: \_\_\_\_\_

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

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

**List ICD Diagnosis Code(s):**

Primary ICD DX: \_\_\_\_\_

Symptoms: \_\_\_\_\_

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

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

## Justification of Medical Necessity

**\*\*You may attach/fax all relevant clinical documentation—if so, please write see attached\*\***

## Current Course of Treatment/ Treatment History

### TREATMENT TYPE

- |   |  |                 |
|---|--|-----------------|
| <input type="checkbox"/> Breathing Treatment  | Nebulizer Medication _____   | Frequency _____ |
| <input type="checkbox"/> Chest Tube           |  |                 |
| <input type="checkbox"/> Dialysis             | Dialysis Type _____  | Frequency _____ |
| <input type="checkbox"/> Enteral Feedings     | Enteral Name _____   | Frequency _____ |
| <input type="checkbox"/> GI Suction           |  |                 |
| <input type="checkbox"/> Insulin Adjustment   |  |                 |
| <input type="checkbox"/> Isolation            | Isolation Type _____   |                 |
| <input type="checkbox"/> IV Feedings          | IV Feedings Name _____   | Frequency _____ |
| <input type="checkbox"/> IV Fluids            | IV Fluids Name _____   | Frequency _____ |
| <input type="checkbox"/> IV Medication        | IV Medication _____  | Frequency _____ |
| <input type="checkbox"/> Mobility Aids        | Type _____   |                 |
| <input type="checkbox"/> Occupational Therapy |  | Frequency _____ |
| <input type="checkbox"/> Other                | <input type="text"/>   |                 |
| <input type="checkbox"/> Oxygen               | Liters of or % of O <sub>2</sub> _____   | Frequency _____ |
|   | Oxygen Saturation _____ Room Air _____ With O <sub>2</sub> _____ Liters or % _____ |                 |
| <input type="checkbox"/> Pain Management      |  |                 |
| <input type="checkbox"/> Physical Therapy     | Frequency _____  |                 |
| <input type="checkbox"/> Respiratory Suction  |  |                 |
| <input type="checkbox"/> Speech Therapy       | Frequency _____  |                 |
| <input type="checkbox"/> Ventilator           |  |                 |

NOTE: