WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8427 OUTPATIENT SERVICES**

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 WVCHIP)

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 WVCHIP)

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

Member WVCHIP Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Authorization Type: ☐**Prior Authorization** ☐**Retrospective WVCHIP Eligibility**

List Other Retro Reason:

Place of Service: ☐**Office** ☐**OTHER (Please Indicate)**: _____

SERVICE START DATE: _____

LIST ALL RELEVANT ICD DIAGNOSIS CODE(S):

Primary DX: _____ Symptoms: _____

Services Requested- Please include all relevant clinical information REQUIRED for medical necessity review

☐**Evaluation & Management CPT code(s):** _____

☐**Initial Consultation CPT code(s):** _____

☐**2nd Opinion Consultation CPT code(s):** _____

☐**Other:** _____