



WVCHIP PRIOR AUTHORIZATION FORM

FAX 1-844-633-8430 PRIVATE DUTY NURSING

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 _____

Member Address, City, State, ZIP _____

Procedure Type: PRIVATE DUTY NURSING

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

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

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

Other DX: _____

CPT/Service Code Requested: T1000 **Number of Units** _____

Circle Approximate Length of Time Needed: Less than 1 month 01-03 months 04-06 months 07-09 months 10-12 months Greater than 12

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

PROGNOSIS

JUSTIFICATION OF MEDICAL NECESSITY

MEMBER IS MEDICALLY STABLE Yes No

VENTILATOR DEPENDENT Yes No

If yes, Ventilator hours per day _____

Does Patient Have:	Yes	No
Impaired Endurance		
Impaired Mobility		
Impaired Respiration		
Impaired Speech		
Restricted Activity		
Skin Breakdown		
Require Assistance with ADL's		
Caregiver Support Available		
Caregiver is available/willing to receive education necessary to provide services to the member		

Please include the following REQUIREMENTS:

- Physician's Plan of Care
- Private Duty Nursing Acuity Grid
- Private Duty Nursing Home Psychosocial Grid

Caregiver Explanation if No:

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 LPM: _____ Hours per Day : _____

NON-VENTILATOR DEPENDENT TRACHEOSTOMY Yes No

PLEASE DESCRIBE FUNCTIONAL LIMITATIONS RELATED TO ADL:

PLEASE ANSWER THE FOLLOWING IF APPLICABLE:

- Occupational Therapy Weekly Bi-weekly Monthly Other
- Physical Therapy Weekly Bi-weekly Monthly Other
- Speech Therapy Weekly Bi-weekly Monthly Other
- Other Therapy Weekly Bi-weekly Monthly Other

DESCRIBE OTHER THERAPY AND FREQUENCY

PLEASE LIST OR ATTACH A MAR SHOWING NAME, STRENGTH, ROUTE, PRESCRIBED DATE, QUANTITY AND FREQUENCY:

ADDITIONAL ANNOTATION: