



# WVCHIP PRIOR AUTHORIZATION FORM

## FAX 1-844-633-8429 PULMONARY REHAB

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/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 \_\_\_\_\_

Member Address, City, State, ZIP \_\_\_\_\_

Procedure Type: Pulmonary Rehab Patient Status:  New  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:  Office  Clinic  OP Hospital

### List ALL Relevant ICD Diagnosis Code(s):

Primary DX: \_\_\_\_\_ Symptoms: \_\_\_\_\_  
Other DX: \_\_\_\_\_

### CIRCLE Service Code(s) Requested:

START DATE \_\_\_\_\_

\_\_\_\_\_ **GO237** \_\_\_\_\_ **G0238** \_\_\_\_\_ **G0239**

Are the physician orders for each code attached? \_\_\_Yes \_\_\_No If No, please list why:

\_\_\_\_\_

**MARK ALL APPLICABLE AND SUPPLY JUSTIFICATION OF MEDICAL NECESSITY FOR INITIAL ADMISSION:**

	Chronic Pulmonary Disease
	Member does not have a recent history of smoking or has quit smoking for at least 3 months
	Other Condition that affects Pulmonary Function
	Reduction of exercise tolerance restricting the ability to perform activities of daily living.

**JUSTIFICATION OF MEDICAL NECESSITY**

**TREATMENT PLAN-PREVIOUS COURSE OF TREATMENT**

**CURRENT PLAN OF CARE**

**FREQUENCY # OF SESSIONS/WEEK** \_\_\_\_\_ **Start Date** \_\_\_\_\_ **End Date** \_\_\_\_\_

**PLANNED INTERVENTION/TREATMENTS-EXERCISE TRAINING DURATION**  20 Minutes  40 Minutes  60 Minutes  Other

**DESCRIPTION OF OTHER:**

**PLANNED INTERVENTIONS/TREATMENTS EXERCISE/TRAINING SESSION (Check all applicable)**

- Exercise Program  Team Assessment  Member Follow-Up  Psychosocial Intervention

**MEMBER TRAINING/EDUCATION (Check all applicable)**

- Breathing Retraining  Bronchial Hygiene  Medication Education  Nutrition Education

**PSYCHOSOCIAL INTERVENTION (Check all Applicable)**

- Anxiety Evaluation & Management  Assessment/Development of emotional support systems  
 Dependency Issues/Evaluation Management  Other Psychosocial

**PLANNED INTERVENTIONS/TREATMENTS EXERCISE/TRAINING SESSION EXPLANATION**

**EXPECTED OUTCOMES/GOALS (Check all applicable)**

- Educate Members/Significant Others about the disease, treatment options and strategies  
 Encourage Members to be actively involved in healthcare  Maintain Health Behaviors  
 Reduce/Control breathing difficulties and symptoms  Restore the member to the highest possible level of independent function

**ADDITIONAL ANNOTATION:**