



CONFIDENTIAL SUPPORTING DOCUMENTATION FOR EXISTING C3 PROVIDER PORTAL CASE



WVCHIP MEDICAL C3 CARECONNECTION® PROVIDER PORTAL PRIOR AUTHORIZATIONS

PLEASE INDICATE THE INTENDED RECIPIENT AND FAX TO THE CORRESPONDING NUMBER

- | | | |
|---|--|---|
| <input type="checkbox"/> 1.844.633.8426
<i>INPATIENT (ACUTE)</i>
<i>INPATIENT REHAB UNDER 21</i>
<i>ORGAN TRANSPLANTS</i>
<i>BARIATRIC</i> | <input type="checkbox"/> 1.844.633.8428
<i>IMAGING/RADIOLOGY/LAB</i> | <input type="checkbox"/> 1.844.633.8430
<i>HOSPICE/HOME HEALTH</i>
<i>PRIVATE DUTY NURSING</i> |
| <input type="checkbox"/> 1.844.633.8427
<i>OUTPATIENT SURGERY</i> | <input type="checkbox"/> 1.844.633.8429
<i>DME</i>
<i>ORTHOTICS & PROSTHETICS</i>
<i>CARDIAC/PULMONARY REHAB</i> | <input type="checkbox"/> 1.844.633.8431
<i>SPEECH/AUDIOLOGY</i>
<i>PT/OT</i>
<i>DENTAL/ORTHODONTIC</i>
<i>VISION</i>
<i>PODIATRY</i>
<i>CHIROPRACTIC</i> |

Date:	
Member Name:	Member WVCHIP ID:
Authorization Request ID: (from C3 CareConnection® Provider Portal)	
Please mark the following Request Type:	<input type="checkbox"/> ORIGINAL <input type="checkbox"/> RECONSIDERATION
COMMENT:	

Submitting C3 Org:	
Provider Name & Provider ID:	
Contact Name:	
Provider Telephone:	Provider Facsimile:

CONFIDENTIALITY NOTICE

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- ENCLOSED SUPPORTING DOCUMENTATION IS AS FOLLOWS:** **# OF PAGES** _____
- | | | |
|---|---|---|
| <input type="checkbox"/> Plan of Care/Treatment Plan | <input type="checkbox"/> Signature Page(s)/Certifications | <input type="checkbox"/> Prescription/Practitioner's Order
(signed/dated within the last 6 months) |
| <input type="checkbox"/> Dental Molds | <input type="checkbox"/> Certificate of medical necessity (CMN) | |
| <input type="checkbox"/> Labs/Diagnostic Test Results | <input type="checkbox"/> Medication Administration Record (MAR) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Treatment Notes/Progress Notes | <input type="checkbox"/> OASIS (Home Health/PDN) | |
| <input type="checkbox"/> Referral/Authorization Request | <input type="checkbox"/> History and Physical | |
| <input type="checkbox"/> X-Rays/Radiographs | | |

<https://providerportal.kepro.com>