

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

FAX 1.844-633-8429 ORTHOTICS/PROSTHETICS

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 WV Medicaid)

<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 WV Medicaid)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>
<b>Address, City, State, Zip</b>	

Member Medicaid Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

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

Procedure Type:  ORTHOTICS  PROSTHETICS Place of Service: OFFICE

List Other Retro Reason:

Authorization Type:  Prior Authorization

Retrospective Request, if applicable list the appropriate reason:

Denied by Member's Primary Payer  Retrospective Medicaid Eligibility

For Members under age 21, is this request an EPSDT referral?  Yes  NO \*\*If yes, please submit the most current EPSDT form on file\*\*

Type of Admission/Procedure:  Emergency/Medically Urgent  Non-Urgent Request Type:  New  Repair  Replacement

## 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: \_\_\_\_\_ Number of Units \_\_\_\_\_ Start Date \_\_\_\_\_

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

CPT/Service Code Requested: \_\_\_\_\_ Number of Units \_\_\_\_\_ Start Date \_\_\_\_\_

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

Height: \_\_\_\_\_ Measurement  Centimeters  Inches

Weight: \_\_\_\_\_ Measurement  Kilos  Pounds BMI: \_\_\_\_\_

Date Last Examined by Practitioner \_\_\_\_\_

Functional Level:  Level-0  Level-I  Level-II  Level-III  Level-IV

### JUSTIFICATION OF MEDICAL NECESSITY

Does Patient Have:

- Impaired Endurance  Yes  No
- Impaired Hearing  Yes  No
- Impaired Mobility  Yes  No
- Impaired Respiration  Yes  No
- Impaired Speech  Yes  No
- Impaired Vision  Yes  No
- Restricted Activity  Yes  No
- Skin Breakdown  Yes  No
- Require Assistance with ADL's  Yes  No

NOTES:

Does the Patient and/or Caregiver demonstrate:

- Willingness and ability to use equipment  Yes  No  N/A
- Is item suitable for use in home?  Yes  No  N/A

Justification of Medical Necessity:

Are Physician's Order(s) Signed, Dated, and Attached?  Yes  No Date of Order: \_\_\_\_\_

\*\*\*I certify that this patient meets the program eligibility criteria and that this equipment is a part of the course of treatment and is reasonable, medically necessary and is most cost effective and is not a convenience item for the recipient, family, attending practitioner or supplier. To my knowledge, the above information is accurate.\*\*\*  Yes  No

Have you attached the signed and dated Prescribing Practitioner Certification of Medical Necessity?  Yes  No

### SUPPLIER/VENDOR INFORMATION

Supplier Name \_\_\_\_\_ Supplier NPI \_\_\_\_\_

Supplier Contact Name \_\_\_\_\_

Supplier Phone Number: \_\_\_\_\_ Supplier Fax Number: \_\_\_\_\_

Supplier Address: \_\_\_\_\_

Supplier City, State, Zip: \_\_\_\_\_