WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8431 PODIATRY**

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 WV Medicaid)

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 WV Medicaid)

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

Member Medicaid Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Procedure Type: PODIATRY

Authorization Type:

☐**Prior Authorization**

☐**Retrospective Request, if applicable list the appropriate reason:**

☐**Denied by Member's Primary Payer** ☐**Retrospective Medicaid Eligibility**

List Other Retro Reason:

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** **Place of Service:** ☐**Office** ☐**OP Hospital** ☐**Surgical Center**

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(s) Requested:

START DATE_____

_____|_____|_____ Are the physician orders for each code attached? ___Yes ___No

If No, please list why:

_____

DESCRIBE PROCEDURE(S)/FUNCTIONAL LEVEL:

I certify that this patient meets the program eligibility criteria and that this equipment is a part 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**

Certification Date: _____

Certifying Practitioner: _____

Certifying Practitioner ID: _____

Certifying Practitioner Phone: _____

MEDICAL EVALUATION

Does patient have impaired endurance? **Medical Justification**	☐**YES**	☐**NO**
Does patient have impaired mobility? **Medical Justification**	☐**YES**	☐**NO**
Does patient have restricted activity? **Medical Justification**	☐**YES**	☐**NO**
Does patient have skin breakdown? (If yes, describe site, size, depth, and drainage below) **Medical Justification**	☐**YES**	☐**NO**
Does patient require assistance with ADLs? **Medical Justification**	☐**YES**	☐**NO**
Does patient/caregiver demonstrate willingness and ability to use equipment? **Medical Justification**	☐**YES**	☐**NO**

Length of Time Needed:

☐**1-2 weeks** ☐**6-8 weeks**
☐**3-4 weeks** ☐**Ongoing**
☐**5-6 weeks**

List Dollar Amount:

Quantity Ordered: **1 2 3 4 5 6 7 8 9 10**

Frequency of Use:	**Functional Level:**
☐ **As Needed**	☐ **0**
☐ **Continuous**	☐ **I**
☐ **Daily**	☐ **II**
☐ **Weekly**	☐ **III**
☐ **Monthly**	☐ **IV**

ADDITIONAL ANNOTATIONS