

WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1-844-633-8429 PULMONARY REHAB

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)

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 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: Pulmonary Rehab Patient Status: New Established

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 Clinic OP Hospital

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____
Other DX: _____

CIRCLE Service Code(s) Requested:

START DATE _____

_____ GO237

_____ GO238

_____ GO239

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: