

WV MEDICAID PRIOR AUTHORIZATION FORM

FAX 1-844-633-8429 CARDIAC 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/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 _____

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:

Patient Status: New Established

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 Independent Clinic OP Hospital

List ICD Diagnosis Code(s): Primary ICD DX: _____ Symptoms: _____ Other DX: _____
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CIRCLE Service Code(s) Requested:	START DATE _____
_____ 93797 # of units _____	_____ 93798 # of units _____

Mark all applicable for Initial Admission and supply Justification of Medical Necessity

<input type="checkbox"/>	Acute Myocardial Infarction
<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	Cardiac Dysrhythmias
<input type="checkbox"/>	Cardiomegaly
<input type="checkbox"/>	Complication of Transplanted Organ; Heart
<input type="checkbox"/>	Functional Disturbances Following Cardiac Surgery
<input type="checkbox"/>	Heart Failure
<input type="checkbox"/>	New Evidence of Ischemia or an exercise test including Thallium scan
<input type="checkbox"/>	Old Myocardial Infarction
<input type="checkbox"/>	Organ/Tissue replaced by other means; Heart
<input type="checkbox"/>	Organ/Tissue replaced by other means; Heart Valve
<input type="checkbox"/>	Other acute & subacute forms of Ischemic Heart Disease
<input type="checkbox"/>	Other Diseases of Endocardium
<input type="checkbox"/>	Other forms of Chronic Ischemic Heart Diseases
<input type="checkbox"/>	Other Post Procedural States; Automatic Implantable Cardiac Defibrillator
<input type="checkbox"/>	Other Post Procedural States; Percutaneous Transluminal Coronary Angioplasty Status
<input type="checkbox"/>	Other Post Procedural States; Unspecified Cardiac Device
<input type="checkbox"/>	Personal history of other Cardio Respiratory Problems; Exercise Intolerance with Pain; at rest; with less than ordinary activity; with ordinary activity

MEDICAL JUSTIFICATION:

PLEASE INDICATE/INCORPORATE ALL ASSOCIATED MEDICATIONS, TREATMENTS, THERAPIES, PREVIOUS DIAGNOSTIC STUDIES, ETC.,
(TO INCLUDE THE RELATION, DURATION, OUTCOMES, ACTIVITY MODIFICATIONS):

Current Plan of Care:

FREQUENCY (# OF) SESSIONS/WEEKS _____ **START DATE** _____ **END DATE** _____

PLANNED INTERVENTION/TREATMENTS-EXERCISE TRAINING DURATION:

20 Minutes 40 Minutes 60 Minutes LIST Other: _____

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

- ECG/EKG Monitoring during exercise
- ECG/EKG rhythm strip with interpretation & physician revision of the exercise program
- Limited physician follow-up to adjust medication or other treatment(s) related to program

EXPECTED GOAL (Check all applicable)

- Improve blood cholesterol levels
- Increase exercise tolerance
- Improve psychosocial well-being
- Reduce Mortality
- Reduce symptoms of chest pain/shortness of breath