

WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1-844-633-8431 PT/OT

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: PT OT 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: Emergency/Medically Urgent Non-Urgent Place of Service: Office OP Hospital

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____
Other DX: _____

CPT Requested: _____ # OF UNITS _____ Start Date: _____
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Are the physician orders for each code attached? ___ Yes ___ No If No, please list why:

PERIOD OF REQUEST: 30 days 60 days 90 days **FREQUENCY OF VISITS:** Biweekly Monthly Weekly

DECLINING FREQUENCY EXPLANATION: _____

SUBJECTIVE COMPLAINTS: _____

PROGNOSIS: _____

OBJECTIVE FINDINGS: _____

EXTENUATING CIRCUMSTANCES: _____

HISTORY OF INJURY AND/OR SURGICAL PROCEDURE FOR CURRENT DIAGNOSIS: _____

SHORT TERM GOALS + EXPECTED DATE MET _____

LONG TERM GOALS + EXPECTED DATE MET _____

HAVE NSAIDS BEEN USED? Yes NO If yes, duration: 0-3 months 3-6 months 6-9 months 9-12 months +12 months

If yes list outcome: _____

If no list why: _____

HAS ACTIVITY MODIFICATION BEEN TRIED? Yes NO If Yes, Length: 1-6 Weeks 7-12 Weeks More than 12 Weeks

If yes list outcome: _____

If no list why: _____

ADDITIONAL TREATMENT PLAN INFORMATION:

- Chiropractic Services Utilized Yes NO
- Chiropractic Services Ongoing Yes NO
- Home Exercise Program Prescribed Yes NO
- Home Exercise Program Frequency Daily Every Other Day 3 Times per week or less Other: _____
- Home Exercise Program Duration 1-6 Weeks 7-12 Weeks More than 12 Weeks
- Home Exercise Program Outcomes: _____

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH SUBMISSION:

- Signed & Dated Physicians Order for Each Requested Service
- Relevant Diagnostic Studies & Medication List
- Progress/Treatment Notes

NOTES: