WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8431 VISION =>21**

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 _____

Authorization Type: ☐**Prior Authorization** **Place of Service: OFFICE**

☐**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** **Date of Last Vision Exam:** _____

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

92002	**Eye Exam & Treatment Initial New Patient**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92004	**Eye Exam & Treatment Comprehensive New Patient**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92012	**Eye Exam & Treatment-Intermediate-Established Patient**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92014	**Eye Exam & Treatment-Comprehensive-Established Patient**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92018	**Eye Exam & Evaluation-Anesthesia-Complete**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92019	**Eye Exam & Evaluation-Anesthesia-Limited**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____

If This Is A Repair Or Replacement Request Please Answer The Following Question:

- **Has Visual Appliance Been Repaired Or Replaced Within The Past Year?** ☐**Yes** ☐**No**
- **If Yes, Please Indicate How Many Times Visual Appliances Have Been Repaired Or Replaced.**
  - **Please Indicate Number Of Times:** _____

ADDITIONAL ANNOTATIONS: