# WV MEDICAID PRIOR AUTHORIZATION FORM

**Today's Date ______________________** **FAX 1-844-633-8430 HOSPICE**

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**<br>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**<br>Do not write "See Above" | **NPI Number** |
|---|---|
| **Address,**<br>**City, State, Zip** | |

**Member Medicaid Number** ________________________________ **DOB** ______________

1 **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:**

**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:** ______________

## List ICD Diagnosis Code(s):

Primary ICD DX: ________________________________________________

Symptoms:

**Is the prognosis for primary diagnosis a terminal with life expectancy of less than six months? Yes______ No_______**

Other Dx:

**ELECTION:**

☐**Election 1**
☐**Election 2**
☐**Election 3**
☐**Election 4**
☐**Subsequent Election**
☐**Additional Subsequent Election Inpatient Stay**

☐**Additional Election 1 Inpatient Stay**
☐**Additional Election 2 Inpatient Stay**
☐**Additional Election 3 Inpatient Stay**
☐**Additional Election 4 Inpatient Stay**

Election Effective Date:

**Service Code:**

☐**Routine Home Care** **Units_______**
☐**Continuous Home Care** **Units_______**
☐**Inpatient Respite Care** **Units_______**
☐**Inpatient Facility Care** **Units_______**
☐**Nursing Facility Reimbursement** **Units_______**

**FOR NURSING FACILITY REIMBURSEMENT (658) ONLY**

**Nursing Home:** ________________________________

**Address:** ________________________________

**Phone:** ________________________________

**Site of Service Provision** ☐**Community/Home** ☐**Hospice Facility** ☐**Inpatient Facility** ☐**Nursing Home**