WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8426 INPATIENT REHAB UNDER 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 _____

Registered 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** _____

Procedure Type: INPATIENT REHAB ≤21 WV002 Place of Service: INPATIENT HOSPITAL

ADMISSION DATE_____

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** ☐ **Direct**

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX:

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

Justification of Medical Necessity

You may attach/fax all relevant clinical documentation—if so, please write see attached

Current Course of Treatment/ Treatment History

TREATMENT TYPE

☐Breathing Treatment	Nebulizer Medication	_____	Frequency_____
☐Chest Tube			
☐Dialysis	Dialysis Type	_____	Frequency_____
☐Enteral Feedings	Enteral Name	_____	Frequency_____
☐GI Suction			
☐Insulin Adjustment			
☐Isolation	Isolation Type	_____	
☐IV Feedings	IV Feedings Name	_____	Frequency_____
☐IV Fluids	IV Fluids Name	_____	Frequency_____
☐IV Medication	IV Medication	_____	Frequency_____
☐Mobility Aids	Type	_____	
☐Occupational Therapy			Frequency_____

☐Other

☐Oxygen Liters of or % of 02_____ Frequency_____

Oxygen Saturation_____ Room Air_____ With O2_____ Liters or %_____

☐Pain Management

☐Physical Therapy Frequency_____

☐Respiratory Suction

☐Speech Therapy Frequency_____

☐Ventilator

NOTE: