WVCHIP 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 WVCHIP)

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 WVCHIP)

Name Do not write "See Above"	**NPI Number**
Address, **City, State, Zip**	

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Member WVCHIP Number ____ **DOB**______________________

Member First Name ____ **Last Name** ____

Authorization Type:

☐**Prior Authorization**

☐**Retrospective WVCHIP Eligibility**

☐**Retrospective Request, if applicable list the appropriate reason:**

List Other Retro Reason:

T

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**