



# WVCHIP PRIOR AUTHORIZATION FORM

Today's Date \_\_\_\_\_

**FAX 1.844-633-8426 INPATIENT**

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 WVCHIP)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Contact Information</b>	<b>Phone</b>	<b>Fax:</b>

**Place of Service/Service Provider** (Per policy the Place of Service/Service Provider must be actively enrolled with WVCHIP)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>
<b>Address, City, State, Zip</b>	

Member WVCHIP Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Procedure Type:  Elective  General/Acute  Organ Transplant Place of Service: **INPATIENT HOSPITAL WV001**

<b>ADMISSION DATE:</b>	<b>DISCHARGE DATE:</b>
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<b>List Other Retro Reason:</b>
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Authorization Type:  Prior Authorization  Retrospective WVCHIP Eligibility  
 Retrospective Request, if applicable list the appropriate reason:

\*\*\*WVCHIP defines MEDICALLY URGENT as follows: A delay in services could seriously jeopardize 1. the life or health of the consumer; 2. the ability of the consumer to regain function; 3. in the opinion of a physician with knowledge of the consumer's condition, would subject the consumer to severe pain that cannot be adequately managed without care or treatment that is the subject of the case.\*\*\*

**Type of Admission**

- Direct  Direct/Medically Urgent  Elective  Elective/Medically Urgent  Emergency
- Non-Elective  Non-Elective/Medically Urgent  Transplant  Transplant/Medically Urgent  Emergency/Medically Urgent

**Type of Unit**

- Coronary Care Unit  Medical/Surgical  Critical Care Unit  Neonatal Intensive Care Unit (NICU)
- Intensive Care Unit (ICU)  Special Care Nursery  Intermediate Care  Telemetry  Other: \_\_\_\_\_

Does this admission follow observation?  Yes  No If yes, Date of Observation \_\_\_\_\_

If Yes, describe the progression of symptoms/illness plus treatment administered during observation:

**List ICD Diagnosis Code(s):**

Primary ICD DX: \_\_\_\_\_

Symptoms: \_\_\_\_\_  
Other DX: \_\_\_\_\_

**SERVICES REQUESTED:**

- 1. CPT CODE: \_\_\_\_\_ Description: \_\_\_\_\_
- 2. CPT CODE: \_\_\_\_\_ Description: \_\_\_\_\_
- 3. CPT CODE: \_\_\_\_\_ Description: \_\_\_\_\_

Is this a Bariatric Yes No For Panniculectomy CPT 15830 Procedures Weight Loss Ranges: 0-25 26-50 51-75 76-100 100-125 125+

Is this a Breast Reduction? Yes No If yes, please list current bra size \_\_\_\_\_

Is this an Orthopedic Procedure? Yes No

If yes, have NSAIDS been tried? Yes No If yes mark duration: 0-3 months 3-6 months 6-9 months 12+ months 9-12 month

If yes list outcome, if no list why:

If yes, has activity modification been tried? Yes No If yes mark duration: 0-3 months 3-6 months 6-9 months 12+ months 9-12 month

If yes list outcome, if no list why:

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

## FOR ORGAN TRANSPLANT ONLY

- Heart Transplant Adult Liver Bone Marrow Pediatric Liver
- Kidney Left Right
- Pancreas/Kidney Left Right
- Lung Single Double Left Right
- Heart/Lung Single Double Left Right
- Small Intestine
- Cornea Left Right

Is a second organ being transplanted? Yes No If YES, please select reason:

Primary organ defect caused damaged to a second organ and transplant of the primary organ will eliminate the disease

Damage to the second organ will compromise the outcome of the transplant of the primary organ

Additional Notes for Organ Transplant:

**Please Note: If supporting documentation will be sent by mail or fax, please send the H&P, labs, imaging and treatment pertinent to the current admission ONLY. Sending the patient's entire medical record can cause delays in the processing of your request.**