WVCHIP PRIOR AUTHORIZATION FORM

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

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 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**	

Member WVCHIP Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

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

ADMISSION DATE: _____

List Other Retro Reason:

Authorization Type: ☐**Prior Authorization** ☐**Retrospective WVCHIP Eligibility**

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

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: