



WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1-844-633-8428 LAB/IMAGING/RADIOLOGY

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/Submmiting Organization _____ Please list exactly as registered on C3

Address, City, State, Zip _____

Registered C3 Requesting/Submmiting 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/Serviceing Provider _____ (Per policy the Place of Service/Serviceing 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 _____

Member Address, City, State, ZIP _____

Procedure Type: LAB IMAGING RADIOLOGY

Authorization Type: Prior Authorization Retrospective WVCHIP Eligibility
 Retrospective Request, if applicable list the appropriate reason:

List Other Retro Reason:

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent

Place of Service: Office Home Mobile Unit Urgent Care Facility Inpatient Hospital Outpatient Hospital Emergency Room
 Ambulatory Surgical Center Birthing Center Military Treatment Facility Independent Clinic Independent Lab

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

Other: _____

CPT/Service Code(s) Requested: _____ **START DATE** _____

_____|_____|_____ Are the physician orders for each code attached? ___Yes ___No If No, list why:

Justification of Medical Necessity:

****You may attach H&P and/or other relevant clinical documentation (i.e. previous diagnostic study results)—if so, please write see attached****

Current Course of Treatment

Conservative Treatment History *To include Activity Modifications + NSAID trial—list duration & outcome for both or why not tried.*

****You may attach treatment plan—if so, please write see attached****

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

Is this request pertaining to a Cancer Diagnosis? YES NO

If Yes, Date of Diagnosis: _____

If Yes, Family History of Cancer: YES NO Personal History of Cancer: YES NO

If Yes, Family Member with a known BRCA1/BRCA2 Mutation: YES NO

If Yes, Findings:

If Yes, Diagnosis Ruled Out:

If Yes, this service request is related to:

- Disease Progression Metastasis New Diagnosis New Symptoms
 Recurrence Restaging Treatment Planning

If Yes, Current Course of Treatment: