WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8430 PRIVATE DUTY NURSING**

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**	

Member WVCHIP Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Procedure Type: **PRIVATE DUTY NURSING**

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**

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

****You may attach H&P or other relevant clinical documentation—if so, please write see attached****

Other DX:

CPT/Service Code Requested: **T1000** **Number of Units**_____

Circle Approximate Length of Time Needed: Less than 1 month 01-03 months 04-06 months 07-09 months 10-12 months Greater than 12

Circle Patient's Current Condition: Acute Chronic Long-Term Long-Term Maintenance (condition is stable) Terminal

PROGNOSIS

JUSTIFICATION OF MEDICAL NECESSITY

MEMBER IS MEDICALLY STABLE ☐**Yes** ☐**No** **VENTILATOR DEPENDENT** ☐**Yes** ☐**No** **If yes, Ventilator hours per day** _____

Does Patient Have:	Yes	No
Impaired Endurance		
Impaired Mobility		
Impaired Respiration		
Impaired Speech		
Restricted Activity		
Skin Breakdown		
Require Assistance with ADL's		
Caregiver Support Available		
Caregiver is available/willing to receive education necessary to provide services to the member		

Please include the following REQUIREMENTS:

Physician's Plan of Care
Private Duty Nursing Acuity Grid
Private Duty Nursing Home Psychosocial Grid

Caregiver Explanation if No:

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING CURRENT TREATMENT:

INTRAVENOUS FLUIDS/MEDICATIONS ☐**Yes** ☐**No**

If Yes: Type: _____Dose: _____ Duration:_____Frequency: _____

ENTERAL (TUBE) FEEDINGS ☐**Yes** ☐**No**

If yes, is this the sole source of nutrition? ☐Yes ☐No If Yes, Type of Nutrition: _____ Frequency: _____

OXYGEN ☐**Yes** ☐**No** **LPM:** _____ **Hours per Day :** _____

NON-VENTILATOR DEPENDENT TRACHEOSTOMY ☐**Yes** ☐**No**

PLEASE DESCRIBE FUNCTIONAL LIMITATIONS RELATED TO ADL:

PLEASE ANSWER THE FOLLOWING IF APPLICABLE:

- Occupational Therapy ☐ Weekly ☐Bi-weekly ☐Monthly ☐Other
- Physical Therapy ☐ Weekly ☐Bi-weekly ☐Monthly ☐Other
- Speech Therapy ☐ Weekly ☐Bi-weekly ☐Monthly ☐Other
- Other Therapy ☐ Weekly ☐Bi-weekly ☐Monthly ☐Other

DESCRIBE OTHER THERAPY AND FREQUENCY

PLEASE LIST OR ATTACH A MAR SHOWING NAME, STRENGTH, ROUTE, PRESCRIBED DATE, QUANTITY AND FREQUENCY:

ADDITIONAL ANNOTATION: