WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8431 SPEECH**

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 _____

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

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

List Other Retro Reason:

Type of Procedure: ☐**Emergency/Medically Urgent** ☐**Non-Urgent** **PATIENT STATUS:** ☐**New** ☐**Established**

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX:

****I certify that this patient meets the program eligibility criteria and that this equipment is a part of the course of treatment and is reasonable, medically necessary and is most cost effective and is not a convenience item for the recipient, family, attending practitioner or supplier. To my knowledge, the above information is accurate.**

☐**YES** ☐ **NO**

Please attach *Certificate of Medical Necessity* or appropriate documentation including signatures.

Service Code: **Place of Service:** ☐ **Office** ☐ **Home** ☐ **Public Health Clinic** ☐ **Rural Health Clinic**	**Service Code:** **Place of Service:** ☐ **Office** ☐ **Home** ☐ **Public Health Clinic** ☐ **Rural Health Clinic**	**Service Code:** **Place of Service:** ☐ **Office** ☐ **Home** ☐ **Public Health Clinic** ☐ **Rural Health Clinic**
Units:	**Units:**	**Units:**
Period of Request: ☐30 Days ☐60 Days ☐90 Days	Period of Request: ☐30 Days ☐60 Days ☐90 Days	Period of Request: ☐30 Days ☐60 Days ☐90 Days
Frequency: ☐Weekly ☐Biweekly ☐Monthly	Frequency: ☐Weekly ☐Biweekly ☐Monthly	Frequency: ☐Weekly ☐Biweekly ☐Monthly
Duration of Individual Therapy Services: ☐1 hour ☐15 Minutes ☐30 Minutes ☐Event	Duration of Individual Therapy Services: ☐1 hour ☐15 Minutes ☐30 Minutes ☐Event	Duration of Individual Therapy Services: ☐1 hour ☐15 Minutes ☐30 Minutes ☐Event

Declining Frequency Explanation:

_____

REQUIRED WITH EACH SPEECH REQUEST

		ATTACHED?
Certificate of Medical Necessity	**Date of CMN** _____	☐**Yes** ☐**No** ☐ **N/A**
Signed Physician's Order(s)	**Date of Order** _____	☐**Yes** ☐**No**
Most Recent Progress Notes	**Date of Notes** _____	☐**Yes** ☐**No**
Waiver Letter for School-Aged Children	**Date of Letter** _____	☐**Yes** ☐**No** ☐ **N/A**
Treatment Care Plan	**Date of TCP** _____	☐**Yes** ☐**No**
Individual Education Plan`	**Date of IEP** _____	☐**Yes** ☐**No** ☐ **N/A**
Progress Notes for Past Treatments	**Date of PN** _____	☐**Yes** ☐**No**
Short and Long Term Goals	**Date of Goals** _____	☐**Yes** ☐**No**

For renewal of speech services progress notes and new goals are always required.

NOTES: