CONFIDENTIAL SUPPORTING DOCUMENTATION FOR EXISTING C3 PROVIDER PORTAL CASE

WVCHIP MEDICAL C3 CARECONNECTION® PROVIDER PORTAL PRIOR AUTHORIZATIONS

PLEASE INDICATE THE INTENDED RECIPIENT AND FAX TO THE CORRESPONDING NUMBER

☐ **1.844.633.8426**
INPATIENT (ACUTE)
INPATIENT REHAB UNDER 21
ORGAN TRANSPLANTS
BARIATRIC

☐ **1.844.633.8427**
OUTPATIENT SURGERY

☐ **1.844.633.8428**
IMAGING/RADIOLOGY/LAB

☐ **1.844.633.8429**
DME
ORTHOTICS & PROSTHETICS
CARDIAC/PULMONARY REHAB

☐ **1.844.633.8430**
HOSPICE/HOME HEALTH
PRIVATE DUTY NURSING

☐ **1.844.633.8431**
SPEECH/AUDIOLOGY
PT/OT
DENTAL/ORTHODONTIC
VISION
PODIATRY
CHIROPRATIC

Date:	
Member Name:	**Member WVCHIP ID:**
Authorization Request ID: (from C3 CareConnection® Provider Portal)	
Please mark the following Request Type:	☐ **ORIGINAL** ☐ **RECONSIDERATION**
COMMENT:	

Submitting C3 Org:	
Provider Name & Provider ID:	
Contact Name:	
Provider Telephone:	**Provider Facsimile:**

CONFIDENTIALITY NOTICE

Warning: Unauthorized interception of this telephonic communication could be a violation of Federal Law the documents accompanying this telecopy contain confidential information belonging to the sender which is legally privileged. The information is intended only for use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of the tele-copied information is strictly prohibited. If you have received this telecopy in error, please immediately notify us to arrange the return of the original documents to KEPRO at (800) 346.8272 or email: WVCHIP@kepro.com.

ENCLOSED SUPPORTING DOCUMENATION IS AS FOLLOWS: # OF PAGES_____

☐ **Plan of Care/Treatment Plan**
☐ **Dental Molds**
☐ **Labs/Diagnostic Test Results**
☐ **Treatment Notes/Progress Notes**
☐ **Referral/Authorization Request**
☐ **X-Rays/Radiographs**
☐ **Signature Page(s)/Certifications**
☐ **Certificate of medical necessity (CMN)**
☐ **Medication Administration Record (MAR)**
☐ **OASIS (Home Health/PDN)**
☐ **History and Physical**
☐ **Prescription/Practitioner's Order (signed/dated within the last 6 months)**
☐ **Other (specify):** _____

https://providerportal.kepro.com