

WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1.844-633-8426 INPATIENT REHAB

REGISTRATION ON ATTREZO IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.

DETERMINATIONS ARE AVAILABLE ON <https://portal.kepro.com/>

ATTREZO Requesting/Submitting Organization _____ Please list exactly as registered on ATTREZO

Address, City, State, Zip _____

ATTREZO Requesting/Submitting Organization NPI _____ Please list exactly as registered on ATTREZO

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/Service Provider

(Per policy the Place of Service/Service 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 LOS Place of Service: INPATIENT HOSPITAL

List Other Retro Reason:

ADMISSION DATE: _____

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

<p>List ICD Diagnosis Code(s):</p> <p>Primary ICD DX: _____</p> <p>Symptoms: _____</p> <p>Other DX: _____</p>
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<p>PLEASE INDICATE/INCORPORATE ALL ASSOCIATED MEDICATIONS, TREATMENTS, THERAPIES, PREVIOUS DIAGNOSTIC STUDIES, ETC., (TO INCLUDE THE RELATION, DURATION, OUTCOMES, ACTIVITY MODIFICATIONS):</p>

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

- | | | |
|---|--|-------------------|
| <input type="checkbox"/> Breathing Treatment | Nebulizer Medication _____ | Frequency _____ |
| <input type="checkbox"/> Chest Tube | | |
| <input type="checkbox"/> Dialysis | Dialysis Type _____ | Frequency _____ |
| <input type="checkbox"/> Enteral Feedings | Enteral Name _____ | Frequency _____ |
| <input type="checkbox"/> GI Suction | | |
| <input type="checkbox"/> Insulin Adjustment | | |
| <input type="checkbox"/> Isolation | Isolation Type _____ | |
| <input type="checkbox"/> IV Feedings | IV Feedings Name _____ | Frequency _____ |
| <input type="checkbox"/> IV Fluids | IV Fluids Name _____ | Frequency _____ |
| <input type="checkbox"/> IV Medication | IV Medication _____ | Frequency _____ |
| <input type="checkbox"/> Mobility Aids | Type _____ | |
| <input type="checkbox"/> Occupational Therapy | | Frequency _____ |
| <input type="checkbox"/> Other | <input type="text"/> | |
| <input type="checkbox"/> Oxygen | Liters of or % of O ₂ _____ | Frequency _____ |
| | Oxygen Saturation _____ Room Air _____ With O ₂ _____ | Liters or % _____ |
| <input type="checkbox"/> Pain Management | | |
| <input type="checkbox"/> Physical Therapy | Frequency _____ | |
| <input type="checkbox"/> Respiratory Suction | | |
| <input type="checkbox"/> Speech Therapy | Frequency _____ | |
| <input type="checkbox"/> Ventilator | | |

NOTE: