WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8429 ORTHOTICS/PROSTHETICS**

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 ATREZZO

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/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: ☐ **ORTHOTICS** ☐ **PROSTHETHICS** **Place of Service: OFFICE**

List Other Retro Reason:

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

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

Type of Admission/Procedure: ☐**Emergency/Medically Urgent** ☐**Non-Urgent** **Request Type:** ☐**New** ☐**Repair** ☐**Replacement**

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: _____ **Number of Units**_____ **Start Date**_____

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

CPT/Service Code Requested: _____ Number of Units_____ Start Date_____

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

Height:_____ **Measurement** ☐**Centimeters** ☐ **Inches**

Weight:_____ **Measurement** ☐**Kilos** ☐**Pounds** **BMI:**_____

Date Last Examined by Practitioner_____ **Functional Level:** ☐**Level-0** ☐**Level-I** ☐**Level-II** ☐**Level-III** ☐**Level-IV**

JUSTIFICATION OF MEDICAL NECESSITY

NOTES:

Does Patient Have:

- **Impaired Endurance** ☐**Yes** ☐**No**
- **Impaired Hearing** ☐**Yes** ☐**No**
- **Impaired Mobility** ☐**Yes** ☐**No**
- **Impaired Respiration** ☐**Yes** ☐**No**
- **Impaired Speech** ☐**Yes** ☐**No**
- **Impaired Vision** ☐**Yes** ☐**No**
- **Restricted Activity** ☐**Yes** ☐**No**
- **Skin Breakdown** ☐**Yes** ☐**No**
- **Require Assistance with ADL's** ☐**Yes** ☐**No**

Does the Patient and/or Caregiver demonstrate:

- **Willingness and ability to use equipment** ☐**Yes** ☐**No** ☐**N/A**
- **Is item suitable for use in home?** ☐**Yes** ☐**No** ☐**N/A**

Justification of Medical Necessity:

Are Physician's Order(s) Signed, Dated, and Attached? ☐**Yes** ☐**No** **Date of Order:**_____

******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**

Have you attached the signed and dated Prescribing Practitioner Certification of Medical Necessity? ☐*Yes* ☐*No*

SUPPLIER/VENDOR INFORMATION

Supplier Name_____ **Supplier NPI** _____

Supplier Contact Name_____

Supplier Phone Number: _____ **Supplier Fax Number:**_____

Supplier Address:_____

Supplier City, State, Zip:_____