

WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1.844-633-8431 VISION

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 _____

Member Address, City, State, ZIP _____

Authorization Type: Prior Authorization Place of Service: OFFICE
 Retrospective WVCHIP Eligibility
 Retrospective Request, if applicable list the appropriate reason:

List Other Retro Reason:

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent **Date of Last Vision Exam:** _____

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

CPT CODE		POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
CPT CODE		POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____
CPT CODE		POS: 11 OFFICE # of Units: 1 Start Date: ____/____/____

IF THIS IS A REPAIR OR REPLACEMENT REQUEST PLEASE ANSWER THE FOLLOWING QUESTION:

- HAS VISUAL APPLIANCE BEEN REPAIRED OR REPLACED WITHIN THE PAST YEAR? Yes NO
- IF YES, PLEASE INDICATE HOW MANY TIMES VISUAL APPLIANCES HAVE BEEN REPAIRED OR REPLACED.
 - PLEASE INDICATE NUMBER OF TIMES: _____

ADDITIONAL ANNOTATIONS: