

WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1-844-633-8430 HOSPICE

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 WV Medicaid)

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 WV Medicaid)

Name Do not write "See Above"	NPI Number	
Address, City, State, Zip		

Member Medicaid Number _____ DOB _____

Member First Name _____ Last Name _____

Authorization Type: Prior Authorization
 Retrospective Request, if applicable list the appropriate reason:
 Denied by Member's Primary Payer Retrospective Medicaid Eligibility

List Other Retro Reason:

For Members under age 21, is this request an EPSDT referral? Yes NO **If yes, please submit the most current EPSDT form on file**

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent Place of Service: _____

List ICD Diagnosis Code(s): Primary ICD DX: _____ Symptoms: Is the prognosis for primary diagnosis a terminal with life expectancy of less than six months? Yes _____ No _____ Other Dx: _____
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ELECTION: Election 1 Additional Election 1 Inpatient Stay
 Election 2 Additional Election 2 Inpatient Stay
 Election 3 Additional Election 3 Inpatient Stay
 Election 4 Additional Election 4 Inpatient Stay
 Subsequent Election
 Additional Subsequent Election Inpatient Stay

Election Effective Date:

Service Code: Routine Home Care Units _____
 Continuous Home Care Units _____
 Inpatient Respite Care Units _____
 Inpatient Facility Care Units _____
 Nursing Facility Reimbursement Units _____

FOR NURSING FACILITY REIMBURSEMENT (658) ONLY	
Nursing Home:	_____
Address:	_____
Phone:	_____

Site of Service Provision Community/Home Hospice Facility Inpatient Facility Nursing Home