WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8431 PT/OT**

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 WV Medicaid)

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 WV Medicaid)

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

Member Medicaid Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Procedure Type: ☐ **PT** ☐**OT** **Request Type:** ☐ **Initial** ☐ **Established**

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: ☐**Emergency/Medically Urgent** ☐**Non-Urgent** **Place of Service:** ☐ **Office** ☐**OP Hospital**

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

Other DX:

CPT Requested:_____ **# OF UNITS**_____ **Start Date:**_____

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Are the physician orders for each code attached? ___Yes ___No If No, please list why:

PERIOD OF REQUEST: ☐ 30 days ☐ 60 days ☐ 90 days **FREQUENCY OF VISITS:** ☐Biweekly ☐Monthly ☐Weekly

DECLINING FREQUENCY EXPLANATION: _____

SUBJECTIVE COMPLAINTS: _____

PROGNOSIS: _____

OBJECTIVE FINDINGS: _____

EXTENUATING CIRCUMSTANCES: _____

HISTORY OF INJURY AND/OR SURGICAL PROCEDURE FOR CURRENT DIAGNOSIS: _____

_____

SHORT TERM GOALS + EXPECTED DATE MET _____

_____

LONG TERM GOALS + EXPECTED DATE MET_____

_____

HAVE NSAIDS BEEN USED? ☐**Yes** ☐**NO** If yes, duration: ☐0-3 months ☐3-6 months ☐6-9 months ☐9-12 months ☐+12 months

If yes list outcome: _____

If no list why: _____

HAS ACTIVITY MODIFICATION BEEN TRIED? ☐**Yes** ☐**NO** If Yes, Length: ☐ 1-6 Weeks ☐ 7-12 Weeks ☐ More than 12 Weeks

If yes list outcome: _____

If no list why: _____

ADDITIONAL TREATMENT PLAN INFORMATION:

- Chiropractic Services Utilized ☐Yes ☐NO
- Chiropractic Services Ongoing ☐Yes ☐NO
- Home Exercise Program Prescribed ☐Yes ☐NO
- Home Exercise Program Frequency ☐Daily ☐Every Other Day ☐3 Times per week or less ☐Other:_____
- Home Exercise Program Duration ☐ 1-6 Weeks ☐ 7-12 Weeks ☐ More than 12 Weeks
- Home Exercise Program Outcomes:_____

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH SUBMISSION:

- Signed & Dated Physicians Order for Each Requested Service
- Relevant Diagnostic Studies & Medication List
- Progress/Treatment Notes

NOTES: