WVCHIP OUT-OF-NETWORK PRIOR AUTHORIZATION FORMS

Acentra Health Confidential Fax: 1.866.209.9632- | Telephone: 1.888.571.0262 | Secure Email: **wvchip@kepro.com**

IMPORTANT ANNOUNCEMENT REGARDING REQUESTS FOR OUT-OF-NETWORK SERVICES FOR WVCHIP MEMBERS

All Out-of-Network services requested (EXCEPT where indicated in policy) shall require prior authorization by the Utilization Management Contractor (UMC) before services are provided. Referrals for out-of-network shall be requested by an enrolled WVCHIP provider with required documentation of the established criteria as noted below. Out-of-Network services, except for confirmed emergent situations, shall not be reimbursed when the requested service is available in West Virginia. **The treating physician and facility shall enroll as a WVCHIP provider to be eligible for reimbursement AND accept WVCHIP reimbursement as payment in full.** The approval of services does not guarantee payment. ***Acentra Health does not process OON requests for Managed Care Organization (MCO) WVCHIP members.***

Acentra Health, the current Utilization Management Contractor (UMC) for the WVCHIP program, processes all Out-of-Network requests for WVCHIP members.

The UMC will obtain WVCHIP approval for any OON services deemed medically necessary but not specifically addressed in policy or for expedited enrollment of an OON Provider, if necessary.

A few reminders about Out-of-Network requests for Medical Services for WVCHIP members:

- **ALL Out-of-Network** services requested for WVCHIP members require prior authorization/determination of medically necessity by the Utilization Management Contractor (UMC) **before** services are provided or as soon as possible following delivery of emergency services.

- Out-of-Network services **must** be requested by **an enrolled WVCHIP provider** with **required documentation of medical necessity** (completed request form for the relevant service type and completed OON request form) AND **justification of why requested service(s)** cannot be obtained from an in-network provider (complete relevant sections on the OON request form).

- **Out-of-Network services, with the exception of confirmed emergent situations, shall not be authorized or reimbursed when the requested service is available in West Virginia.**

- The treating Out-of-Network physician and facility **must enroll** as a WVCHIP provider to be eligible for reimbursement, accept WVCHIP's reimbursement as payment in full AND bill under the authorization number granted by the UMC if the request is entered into their systems.

- **As in all cases, prior authorization does not guarantee payment**.

- For requests that have historically been directed to HealthSmart, WVCHIP will forward the request to Acentra Health or direct the caller to fax the request for *Out-of-Network* service and all supporting documentation.

All WVCHIP Out-of-Network request will be processed on the Acentra Health Medical Atrezzo Provider Portal by the UMC contractor to reach the determination of medical necessity—to decrease the time necessary to address these requests they may now be:

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Referring/Ordering Provider

(Per policy the Referring/Ordering Provider must be actively enrolled with WVCHIP)

Name	
WVCHIP ID/NPI	
Address	
City, State, Zip	
Contact Name	**Phone Number**
Confidential Fax Number	
PROVIDER SIGNATURE	**Date**

Out-of-Network Servicing Provider/Practitioner

(Per policy the Servicing Provider/Practitioner must agree to enroll with WVCHIP)

Name	
NPI	**(required)**
Address	
City, State, Zip	
Contact Name	**Phone Number:**
Confidential Fax Number	
THIS PROVIDER AGREES TO ENROLL WITH WVCHIP:	**YES___ NO___** ***It is the responsibility of the provider to enroll in WVCHIP. The approval number cannot be issued thus the claim cannot be paid— even when a service has medical necessity review criteria, if the provider is does not enroll in WVCHIP.***

Out-of-Network Facility/Location

(Per policy the Servicing Facility/Location must also agree to enroll with WVCHIP in conjunction to the Provider/Practitioner)

Name	
NPI	**(required)**
Address	
City, State, Zip	
Contact Name	**Phone Number:**
Confidential Fax Number	
THIS PROVIDER AGREES TO ENROLL WITH WVCHIP:	**YES___ NO___** ***It is the responsibility of the provider to enroll in WVCHIP. The approval number cannot be issued thus the claim cannot be paid— even when a service has medical necessity review criteria, if the provider is does not enroll in WVCHIP.***

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Member WVCHIP ID Number _____

Member SSN _____

Member First Name _____

Member Last Name _____

DOB _____

Parent/Guardian (if Minor) _____

Member Address _____

_____

City, State, ZIP _____

WV County of Residence _____

MEDICAL JUSTIFICATION FOR REFERRING OUT-OF-NETWORK (OON)

Please briefly describe the service(s) being requested:

You may supply further documentation in the form of an attachment/enclosure with this request to construct medical necessity.

Can this service be provided by an enrolled WVCHIP In-Network provider? Yes___ No___ If no, why not?

You may supply further documentation in the form of an attachment/enclosure with this request to construct medical necessity.

Members expected Out-of-Network treatment plan:

You may supply further documentation in the form of an attachment/enclosure with this request to construct medical necessity.

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REQUEST DATE: **AUTHORIZATION/SERVICE START DATE:**

TYPE OF REQUEST

☐ **INPATIENT ADMISSION** ☐ **OUTPATIENT SURGERY** ☐ **OTHER**

☐ **CONSULT**

Upon medical necessity approval for the initial consult of this applicant the Out-of-Network provider agreeing to consult the patient and enroll as a WVCHIP must submit this form for each/all subsequent care that is required for treatment. Each application will be reviewed on a case-by-case basis.

Explanation of Type of Services being requested—Acentra Health may need to contact you for more information based on the services requested under "other"

AUTHORIZATION INFORMATION

☐ **Prior Authorization** ☐ **Retrospective Request**

(mark the reason for retrospective request below and supply all relevant documentation to support)

☐ **After hours/weekend admission** ☐ **Failure to Request** ☐ **Denied by Member's Primary Payer** ☐ **Retrospective WVCHIP Eligibility**

☐ **Other** *Explanation*

Type of Admission/Procedure: ☐ **Emergency/Medically Urgent** ☐ **Non-Urgent** ☐ **Elective** ☐ **Non-Elective** ☐ **Direct Admit** ☐ **Office**

PLACE OF SERVICE

☐ 11-Office
☐ 12-Home
☐ 15-Mobile Unit
☐ 20-Urgent Care Facility
☐ 21-Inpatient Hospital
☐ 22-Outpatient Hospital
☐ 23-Emergency Room-Hospital
☐ 24-Ambulatory Surgical Center
☐ 25-Birthing Center
☐ 26-Military Treatment Facility
☐ 49-Independent Clinic
☐ 81-Independent Laboratory

DIAGNOSIS AND SERVICE CODES REQUESTED

ICD code + DESCRIPTION	CPT SERVICE CODE + DESCRIPTION FOR THIS DX:
ICD code + DESCRIPTION	CPT SERVICE CODE + DESCRIPTION FOR THIS DX:
ICD code + DESCRIPTION	CPT SERVICE CODE + DESCRIPTION FOR THIS DX:

Are Physician's Order(s) included: ☐ **Yes** ☐ **No If No, why?**

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RELEVANT DIAGNOSTIC (LAB.IMAGING.RADIOLOGY) STUDIES PREVIOUSLY PERFORMED

Do you have any relevant diagnostic (Lab.Imaging.Radiology) data? ☐ **Yes** ☐ **No** **If yes, please attach with this request.**

CANCER RELATED DX

Is this request pertaining to a Cancer Diagnosis? ☐ **YES** ☐ **NO**

If Yes, Date of Diagnosis: _____

If Yes, Family History of Cancer: ☐ **YES** ☐ **NO** **Personal History of Cancer:** ☐ **YES** ☐ **NO**

If Yes, Family Member with a known BRCA1/BRCA2 Mutation: ☐ **YES** ☐ **NO**

If Yes, Findings:

If Yes, Diagnosis Ruled Out:

If Yes, this service request is related to:

☐ **Disease Progression** ☐ **Metastasis** ☐ **New Diagnosis** ☐ **New Symptoms**

☐ **Recurrence** ☐ **Restaging** ☐ **Treatment Planning**

If Yes, Current Course of Treatment:

CONSERVATIVE TREATMENT HISTORY

Please describe any/all conservative treatment history tried, succeeded, and/or failed that is relevant to the services requested.

You may supply further documentation in the form of an attachment/enclosure with this request to construct medical necessity.

MEDICATIONS

Is member currently taking medications? ☐ **YES** ☐ **NO** ***If yes, please attach a medication list showing each medication name, strength, route, prescribed reason & date, quantity, and frequency.*** **Please indicate any additional notes here:**