

# WVCHIP 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://atrezzo.acentra.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)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Contact Information</b>	<b>Phone</b>	<b>Fax:</b>

Place of Service/Service Provider \_\_\_\_\_ (Per policy the Place of Service/Service Provider must be actively enrolled with WVCHIP)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Address, City, State, Zip</b>		

Member WVCHIP Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Authorization Type:  Prior Authorization  
 Retrospective WVCHIP Eligibility  
 Retrospective Request, if applicable list the appropriate reason:

**List Other Retro Reason:**

**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: \_\_\_\_\_

**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