

# WVCHIP PRIOR AUTHORIZATION FORM

Today's Date \_\_\_\_\_ **FAX 1-844-633-8427 OUTPATIENT SURGERY**

REGISTRATION ON ATTREZZO IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.

DETERMINATIONS ARE AVAILABLE ON <https://atrezzo.acentra.com/>

ATTREZZO Requesting/Submitting Organization \_\_\_\_\_ Please list exactly as registered on ATTREZZO

Address, City, State, Zip \_\_\_\_\_

ATTREZZO Requesting/Submitting Organization NPI \_\_\_\_\_ Please list exactly as registered on ATTREZZO

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 \_\_\_\_\_

Member Address, City, State, ZIP \_\_\_\_\_

Procedure Type: OP SURGERY Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent

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

**List Other Retro Reason:**

Place of Service: Office Urgent Care Facility OP Hospital Ambulatory Surgical Center Birthing Center Military Treatment Facility

**LIST ALL RELEVANT ICD DIAGNOSIS CODE(S):**

Primary DX: \_\_\_\_\_ Symptoms: \_\_\_\_\_  
Other DX: \_\_\_\_\_

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

*If you have relevant diagnostics that you would like to include please indicate such on this form or include as an attachment with the submission:*

SERVICE START DATE: \_\_\_\_\_

**\*\*Please request the Primary service code for both the Referring/Rendering Provider and the Servicing Provider/Location/Facility\*\***

1. SURGICAL PROVIDER (PHYSICIAN) CPT CODE: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

LIST FACILITY/PLACE OF SERVICE FOR SURGERY: \_\_\_\_\_

2. SURGICAL PROVIDER (PHYSICIAN) CPT CODE: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

LIST FACILITY/PLACE OF SERVICE FOR SURGERY: \_\_\_\_\_

3. SURGICAL PROVIDER (PHYSICIAN) CPT CODE: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

LIST FACILITY/PLACE OF SERVICE FOR SURGERY: \_\_\_\_\_

DESCRIBE SURGICAL PROCEDURE(S) LISTED ABOVE:

IF SURGICAL PROCEDURE IS BREAST-RELATED, PLEASE INDICATE BRA SIZE (PRE-SURGERY) \_\_\_\_\_

Does this admission follow observation?  Yes  No Date Placed in Observation: \_\_\_\_\_

If Yes, describe the progression of symptoms/illness plus treatment administered during observation:

Is this an Orthopedic Procedure?  Yes  No If Yes, please provide description:

Have NSAIDS been tried?  Yes  No If yes, please mark duration  0-3 months  3-6 months  6-9 months  12+ months  9-12 months

If yes list outcome, if no list why:

Has activity modification been tried?  Yes  No If yes, please mark duration  0-3 months  3-6 months  6-9 months  12+ months  9-12 months

If yes list outcome including duration, if no list why:

Please provide description of known *Medical History* and relation to request :

Is the member currently taking medication?  Yes  No

If yes, please attach a MAR showing name, strength, route, prescribed date, quantity and frequency