

WVCHIP PRIOR AUTHORIZATION FORM

FAX 1.844-633-8431 PODIATRY

Today's Date _____

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)

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 WVCHIP)

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

Member WVCHIP Number _____

DOB _____

Member First Name _____

Last Name _____

Member Address, City, State, ZIP _____

Procedure Type: **PODIATRY**

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

List Other Retro Reason:

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent Place of Service: Office OP Hospital Surgical Center

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

****You may attach H&P or other relevant clinical documentation—if so, please write see attached****

Other DX: _____

CPT/Service Code(s) Requested: _____

START DATE _____

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

I certify that this patient meets the program eligibility criteria and that this equipment is a part of treatment and is reasonable, medically necessary, and is most cost effective and is not a convenience item for the recipient, family, attending practitioner, or supplier. To my knowledge, the above information is accurate. YES NO

Certification Date: _____

Certifying Practitioner: _____

Certifying Practitioner ID: _____

Certifying Practitioner Phone: _____

MEDICAL EVALUATION

Does patient have impaired endurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient have impaired mobility? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient have restricted activity? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient have skin breakdown? (If yes, describe site, size, depth, and drainage below) <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient require assistance with ADLs? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient/caregiver demonstrate willingness and ability to use equipment? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	

Length of Time Needed:

<input type="checkbox"/> 1-2 weeks	<input type="checkbox"/> 6-8 weeks
<input type="checkbox"/> 3-4 weeks	<input type="checkbox"/> Ongoing
<input type="checkbox"/> 5-6 weeks	

List Dollar Amount:

ADDITIONAL ANNOTATIONS

Quantity Ordered: 1 2 3 4 5 6 7 8 9 10

Frequency of Use:	Functional Level:
<input type="checkbox"/> As Needed	<input type="checkbox"/> 0
<input type="checkbox"/> Continuous	<input type="checkbox"/> I
<input type="checkbox"/> Daily	<input type="checkbox"/> II
<input type="checkbox"/> Weekly	<input type="checkbox"/> III
<input type="checkbox"/> Monthly	<input type="checkbox"/> IV