

# WVCHIP PRIOR AUTHORIZATION FORM

Today's Date \_\_\_\_\_

**FAX 1.844-633-8431 SPEECH**

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 \_\_\_\_\_

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

List Other Retro Reason:

Type of Procedure:  Emergency/Medically Urgent  Non-Urgent PATIENT STATUS:  New  Established

### List ICD Diagnosis Code(s):

Primary ICD DX: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Other DX: \_\_\_\_\_

**\*\*I certify that this patient meets the program eligibility criteria and that this equipment is a part of the course 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

Please attach *Certificate of Medical Necessity* or appropriate documentation including signatures.

<b>Service Code:</b>  <b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic	<b>Service Code:</b>  <b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic	<b>Service Code:</b>  <b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic
<b>Units:</b>	<b>Units:</b>	<b>Units:</b>
Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days
Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly
Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event

**Declining Frequency Explanation:**

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## REQUIRED WITH EACH SPEECH REQUEST

<b>Certificate of Medical Necessity</b>	<b>Date of CMN</b> _____
<b>Signed Physician's Order(s)</b>	<b>Date of Order</b> _____
<b>Most Recent Progress Notes</b>	<b>Date of Notes</b> _____
<b>Waiver Letter for School-Aged Children</b>	<b>Date of Letter</b> _____
<b>Treatment Care Plan</b>	<b>Date of TCP</b> _____
<b>Individual Education Plan`</b>	<b>Date of IEP</b> _____
<b>Progress Notes for Past Treatments</b>	<b>Date of PN</b> _____
<b>Short and Long Term Goals</b>	<b>Date of Goals</b> _____

*For renewal of speech services progress notes and new goals are always required.*

**NOTES:**

## ATTACHED?

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No