

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

FAX 1.844-633-8431 AUDIOLOGY

REGISTRATION ON ATREZZO 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 ATREZZO

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

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

Person Submitting Request \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Referring/Ordering Provider** (Per policy the Referring/Ordering Provider must be actively enrolled with WV Medicaid)

<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 WV Medicaid)

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

Member Medicaid Number \_\_\_\_\_ DOB \_\_\_\_\_

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

Procedure Type: AUDIOLOGY PATIENT STATUS:  New  Established

Authorization Type:  Prior Authorization

Retrospective Request, if applicable list the appropriate reason:

Denied by Member's Primary Payer  Retrospective Medicaid Eligibility

List Other Retro Reason:

For Members under age 21, is this request an EPSDT referral?  Yes  NO \*\*If yes, please submit the most current EPSDT form on file\*\*

Type of Admission/Procedure:  Emergency/Medically Urgent  Non-Urgent Place of Service: OFFICE

## List ICD Diagnosis Code(s):

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

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

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

Type of Hearing Loss:  Conductive  Mixed  Sensorineural

## Severity of Hearing Loss:

Left Ear  No Hearing Impairment  Mild 25-40 dB HL  Moderate 41-70 dB HL  Severe 71-90 dB HL  Profound >91 dB HL dB

Right Ear  No Hearing Impairment  Mild 25-40 dB HL  Moderate 41-70 dB HL  Severe 71-90 dB HL  Profound >91 dB HL dB

## SERVICE SELECTION

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

Declining Frequency of Visits Explanation: \_\_\_\_\_

If Member is under age 21, does member have an Individual Education Plan (IEP) that includes these services?  Yes  No If yes, please attach a copy.

**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.

**Medical History: Please include prior use of hearing aids and other intervention services. *\*\*You may include clinical documentation—write see attached\*\****

Date of Medical Examination: \_\_\_\_\_ **(INCLUDE ALL RELEVANT DIAGNOSTIC STUDY RESULTS, MEDICATIONS, EXAM FINDINGS)**

Medical Examination Findings:

Date of Most Recent Audiological Evaluation (Required): \_\_\_\_\_ Attached?  Yes  No

Date of Most Recent Audiologist Treatment Care Plan (Required): \_\_\_\_\_ Attached?  Yes  No

Date of Most Recent Signed/Dated Physician Order (Required): \_\_\_\_\_ Attached?  Yes  No

Have you attached the required COST INVOICE and COST CALCULATION FORM if selecting a hearing aid code?  Yes  No

Date of Cochlear Implant Placement: \_\_\_\_\_  
*Reason for Cochlear Implant Replacement*

Date of Cochlear Implant Repair: \_\_\_\_\_  
*Reason for Cochlear Implant Repair*

**PLEASE PROVIDE AUDIOLOGY DEVICE INFORMATION:**

Make/Model: \_\_\_\_\_

Expiration Date : \_\_\_\_\_

Date of Placement: \_\_\_\_\_

Success: \_\_\_\_\_

Date of Warranty: \_\_\_\_\_

\_\_\_\_\_

NOTES: