

WV MEDICAID PRIOR AUTHORIZATION FORM

FAX 1-844-633-8429 DME

Today's Date _____

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 WV Medicaid)

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 WV Medicaid)

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

Member Medicaid Number _____ DOB _____

Member First Name _____ Last Name _____

Member Address, City, State, ZIP _____

Service Type: **DME** Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent

Authorization Type: Prior Authorization

Retrospective Request, when applicable list the appropriate reason:

Denied by Member's Primary Payer Retrospective Medicaid Eligibility

Request Type: New Repair Replacement

Length of Time Needed: Days Months Ongoing Permanent Weeks Years

List Other Retrospective Reason:

For Members under age 21:

1. Is this request an EPSDT referral? Yes NO *If yes, please submit the most current EPSDT form on file*
2. Does member have an Individual Education Plan(IEP) that includes these services? Yes No *If yes, please attach a copy.

DOCUMENTS TO BE SUBMITTED:

- | | | | | |
|--|----------------------|-----|----|-----|
| • Certificate of Medical Necessity | Date of CMN _____ | Yes | No | |
| • Signed Physician's Order(s) | Date of Order _____ | Yes | No | |
| • Most Recent Progress Notes | Date of Notes _____ | Yes | No | N/A |
| • Waiver Letter for School-Aged Children | Date of Letter _____ | Yes | No | N/A |
| • Treatment Care Plan | Date of TCP _____ | Yes | No | N/A |
| • Members <21 Individual Education Plan | Date of IEP _____ | Yes | No | N/A |
| • OTHER DOCUMENTS ATTACHED _____ | | | | |

START DATE

**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 information included on this application is accurate. Yes No

LIST DME CPT/HCPC:

MAKE A COPY OF THIS PAGE FOR MULTIPLE CPT/HCPC CODES AND SUBMIT A PAGE PER

CPT/HCPC-Quantity Ordered:

Frequency of Use:

ICD DX Code(s):

b

Symptoms:

Date of Anticipated Equipment Replacement:

DME Vendor Cost Quote \$

ATTACH Cost Invoice/Calculation

Clinical Indications for Items Requested—Mark all Applicable

Medical Equipment

General Medical Equipment

Other Medical Equipment: _____

Enteral Nutrition, If Yes-Enteral Feedings Product _____ Enteral Feedings Frequency _____

PLEASE CIRCLE ALL APPLICABLE CRITERIA BELOW FOR ENTERAL NUTRITION:

- Permanent Impairment > 90 days from onset
- Caloric Intake > 50% Daily
- Impaired digestion, malabsorption or nutritional risk as indicated in anthropometric measures
- Weight loss for adults showing: Involuntary or acute weight loss greater than or equal to 10% of usual body weight during a 3-6 month period or BMI below 18.5 kg/m2.
- Weight loss for neonates, infants and children showing: Very low birth weight(LBW)even in the absence of gastrointestinal, pulmonary or cardiac disorders. Lack of weight gain or weight gain less than 2 standard deviations below the age appropriate mean in a 1 month period for children under 6 months or in a 2 month period for children 6-12 months. No weight gain or abnormally slow rate of gain for 3 months for children older than 1 year or documented weight loss does not reverse promptly with instruction in appropriate diet for age. Weight for height less than the 10th percentile.
- Abnormal laboratory test pertinent to the diagnosis
- Anatomic structure of the gastrointestinal tract that impairs digestion and absorption
- Diagnosis of inborn errors or metabolism that require food products modified low in protein
- Failure to Thrive(FTT) diagnosis that increases caloric need while impairing caloric intake and/or retention
- Increased metabolic and/or caloric needs due to excessive burns, infection, trauma, prolonged fever, hyperthyroidism or illnesses that impair caloric intake and/or retention
- Neurological disorders that impair chewing or swallowing
- Prolonged nutrient losses due to malabsorption syndromes or short bowel syndrome, diabetes, celiac disease, chronic pancreatitis, renal dialysis, draining abscess or wounds
- Treatments with anti-nutrient or catabolic properties

Feeding Tube

IV Infusion Therapy

Mobility and Bathroom Safety Aids

Bathroom Safety Aids

LIST Other Mobility Aids: _____

Wheelchair Manual

Power (Be sure to Complete Page 3)

Medical Supplies

Ostomy Supplies

Incontinence Supplies, CIRCLE reason below:

- Patient has a congenital urinary tract abnormality causing incontinence
- Patient has a developmental delay with urogenital sequelae
- Patient has a neuromuscular defect causing incontinence
- Other clinical evidence to support incontinence or inability to toilet train

Respiratory Equipment

BiPAP

CPAP

Nebulizer

Respiratory Equip-Ventilator

Oxygen(O2)

- Oxygen Liters or % of O2 Administered: _____ Oxygen Saturation: _____

Respiratory Equip-Breathing Treatment

- Breathing Treatment-Medication Administered _____ Breathing Treatment-Frequency _____

Infant Apnea Monitors

- a) Birth Weight _____ Gestational Age(in weeks) _____
- b) Sibling of SIDS Yes No
- c) Infant with Narcotic Addict Mother Yes No
- d) Infant with High-Risk Cardiac Disease Yes No
- e) Infant with Tracheostomy Yes No
- f) Prematurity Yes No
- g) Parent/Guardian Certification (Attached Yes No)
- h) Apnea Delay Rate(in seconds) _____
- i) Apparent Life Threatening Event(ALTE) Yes No If Yes, complete below and attach all relevant ALTE documentation. Date of ALTE _____
 Number of ALTE Episodes _____ ALTE Hospital Name _____
 ALTE Hospital Admission Date _____ Discharge Date _____ Follow-up appointment date: _____

Other: _____

ANSWER ALL QUESTIONS FOR A WHEELCHAIR REQUEST

Is there a current placement? Yes No

Date of Environmental Assessment _____

If Yes, Type of Equipment: _____

Other Equipment Utilized Effectively: _____

How far can the person ambulate unassisted? >150 feet 0-50 feet 51-100 Feet 101-150 feet

Member is expected to grow in height Member may increase in weight/width up to 5 inches

Member requires special developmental capability Member weighs less than 125 pounds

Member may require a seat-to-back angle range of adjustment in excess of 12 degrees

Is there a current placement	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How far can the person ambulate unassisted?	>150 feet <input type="checkbox"/> 0-50 feet <input type="checkbox"/>	101-150 feet <input type="checkbox"/> 51-100 Feet <input type="checkbox"/>
Is this equipment modifiable to meet the member's future needs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
An environmental and functional assessment has been completed to determine that the equipment recommended based on the Physician's order is the most appropriate and cost effective to meet the member's basic health care needs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is wheelchair warranty in place for at least one year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Can repairs be safely made to the current equipment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If answer to questions 3-6 above is NO, please provider explanation here		
How was it determined that the wheelchair selected can be utilized effectively in the member's current environment?	Home/Site Visit <input type="checkbox"/> Member of Caregiver Report <input type="checkbox"/>	Equipment Utilized Effectively-Other <input type="checkbox"/> Other: <input type="checkbox"/>
Length of time member will use wheelchair daily	<2 hrs per day <input type="checkbox"/> 2-8 Hrs per day <input type="checkbox"/>	9-12 Hrs per day <input type="checkbox"/> >12 hrs per day <input type="checkbox"/>
The member will use the wheelchair primarily/routinely	Both inside and outside of the home <input type="checkbox"/> Indoors on smooth hard surfaces <input type="checkbox"/>	Outside: rough/unpaved/uneven surface <input type="checkbox"/> Outside on smooth paved surfaces <input type="checkbox"/>
The Member will encounter obstacles	<=.75 inches <input type="checkbox"/> <.75 in.-<=1.5 in. <input type="checkbox"/>	>1.5 inches-<=2.5 inches <input type="checkbox"/> >2.5 inches <input type="checkbox"/>
The Member has a documented medical need for a feature not routinely available on a lower level Power Wheelchair(PWC)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, Describe the required feature and the environment in which the PWC will be used and the routine performance of ADLS		
The Members requires a drive control interface other than hand or chin operated standard proportional joystick	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, Control-Interface Explanation		
The member has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair and/or the member uses a ventilator that is mounted on the wheelchair	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, Power tilt and recline seating explanation plus describe the ADLs that will be possible with the additional feature that would not be possible with the additional feature:		