WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8430 HOSPICE**

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 ATREZZO

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/Servicing Provider (Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

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

Member Medicaid Number _____ **DOB**_____

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Member First Name _____ **Last Name** _____

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:** _____

List ICD Diagnosis Code(s): Primary ICD DX: _____

Symptoms:

Is the prognosis for primary diagnosis a terminal with life expectancy of less than six months? Yes_____ No_____

Other Dx:

ELECTION:

☐ **Election 1**
☐ **Election 2**
☐ **Election 3**
☐ **Election 4**
☐ **Subsequent Election**
☐ **Additional Subsequent Election Inpatient Stay**
☐ **Additional Election 1 Inpatient Stay**
☐ **Additional Election 2 Inpatient Stay**
☐ **Additional Election 3 Inpatient Stay**
☐ **Additional Election 4 Inpatient Stay**

Election Effective Date:

Service Code:

☐ **Routine Home Care** **Units**_____
☐ **Continuous Home Care** **Units**_____
☐ **Inpatient Respite Care** **Units**_____
☐ **Inpatient Facility Care** **Units**_____
☐ **Nursing Facility Reimbursement** **Units**_____

FOR NURSING FACILITY REIMBURSEMENT (658) ONLY

Nursing Home: _____

Address: _____

Phone: _____

Site of Service Provision ☐ **Community/Home** ☐ **Hospice Facility** ☐ **Inpatient Facility** ☐ **Nursing Home**