

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

**FAX 1.844-633-8426 INPATIENT REHAB**

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)

<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 \_\_\_\_\_

Service Type: **INPATIENT REHAB LOS** Place of Service: **INPATIENT HOSPITAL**

List Other Retro Reason:

ADMISSION DATE \_\_\_\_\_

Request Type:  Prior Authorization  
 Retrospective Request, if applicable list the appropriate reason:  
 Denied by Member's Primary Payer  Retrospective Medicaid Eligibility

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  Direct

<b>List ICD Diagnosis Code(s):</b>
Primary ICD DX: _____
Symptoms: _____
Other DX: _____

<b>PLEASE INDICATE/INCORPORATE ALL ASSOCIATED MEDICATIONS, TREATMENTS, THERAPIES, PREVIOUS DIAGNOSTIC STUDIES, ETC., (TO INCLUDE THE RELATION, DURATION, OUTCOMES, ACTIVITY MODIFICATIONS):</b>

## Justification of Medical Necessity

**\*\*You may attach/fax all relevant clinical documentation—if so, please write see attached\*\***

## Current Course of Treatment/ Treatment History

### TREATMENT TYPE

- |   |  |                   |
|---|--|-------------------|
| <input type="checkbox"/> Breathing Treatment  | Nebulizer Medication _____                                       | Frequency _____   |
| <input type="checkbox"/> Chest Tube           |  |                   |
| <input type="checkbox"/> Dialysis             | Dialysis Type _____  | Frequency _____   |
| <input type="checkbox"/> Enteral Feedings     | Enteral Name _____   | Frequency _____   |
| <input type="checkbox"/> GI Suction           |  |                   |
| <input type="checkbox"/> Insulin Adjustment   |  |                   |
| <input type="checkbox"/> Isolation            | Isolation Type _____   |                   |
| <input type="checkbox"/> IV Feedings          | IV Feedings Name _____   | Frequency _____   |
| <input type="checkbox"/> IV Fluids            | IV Fluids Name _____   | Frequency _____   |
| <input type="checkbox"/> IV Medication        | IV Medication _____  | Frequency _____   |
| <input type="checkbox"/> Mobility Aids        | Type _____   |                   |
| <input type="checkbox"/> Occupational Therapy |  | Frequency _____   |
| <input type="checkbox"/> Other                | <input type="text"/>   |                   |
| <input type="checkbox"/> Oxygen               | Liters of or % of O <sub>2</sub> _____                           | Frequency _____   |
|   | Oxygen Saturation _____ Room Air _____ With O <sub>2</sub> _____ | Liters or % _____ |
| <input type="checkbox"/> Pain Management      |  |                   |
| <input type="checkbox"/> Physical Therapy     | Frequency _____  |                   |
| <input type="checkbox"/> Respiratory Suction  |  |                   |
| <input type="checkbox"/> Speech Therapy       | Frequency _____  |                   |
| <input type="checkbox"/> Ventilator           |  |                   |

NOTE: