

WV MEDICAID PRIOR AUTHORIZATION FORM

FAX 1.844-633-8426 INPATIENT

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 _____

Service Type: Inpatient Surgical General/Acute Organ Transplant Place of Service: **INPATIENT HOSPITAL LOS**

ADMISSION DATE:	DISCHARGE DATE:
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List Other Retro Reason:

Authorization 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**

The WV Bureau for Medical Services defines MEDICALLY URGENT as follows: A delay in services could seriously jeopardize 1. the life or health of the consumer; 2. the ability of the consumer to regain function; 3. in the opinion of a physician with knowledge of the consumer's condition, would subject the consumer to severe pain that cannot be adequately managed without care or treatment that is the subject of the case.

Type of Admission
 Direct Direct/Medically Urgent Elective Elective/Medically Urgent Emergency
 Non-Elective Non-Elective/Medically Urgent Transplant Transplant/Medically Urgent Emergency/Medically Urgent

Type of Unit
 Coronary Care Unit Medical/Surgical Critical Care Unit Neonatal Intensive Care Unit (NICU)
 Intensive Care Unit (ICU) Special Care Nursery Intermediate Care Telemetry Other: _____

Does this admission follow observation? Yes No If yes, Date of Observation _____

If Yes, describe the progression of symptoms/illness plus treatment administered during observation:

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

SERVICES REQUESTED:

- 1. CPT CODE: _____ Description: _____
- 2. CPT CODE: _____ Description: _____
- 3. CPT CODE: _____ Description: _____

Is this a Bariatric Yes No For Panniculectomy CPT 15830 Procedures Weight Loss Ranges: 0-25 26-50 51-75 76-100 100-125 125+

Is this a Breast Reduction? Yes No If yes, please list current bra size _____

Is this an Orthopedic Procedure? Yes No

If yes, have NSAIDS been tried? Yes No If yes mark duration: 0-3 months 3-6 months 6-9 months 12+ months 9-12 month

If yes list outcome, if no list why:

If yes, has activity modification been tried? Yes No If yes mark duration: 0-3 months 3-6 months 6-9 months 12+ months 9-12 month

If yes list outcome, if no list why:

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

FOR ORGAN TRANSPLANT ONLY

Heart Transplant Adult Liver Bone Marrow Pediatric Liver

Kidney Left Right

Pancreas/Kidney Left Right

Lung Single Double Left Right

Heart/Lung Single Double Left Right

Small Intestine

Cornea Left Right

Is a second organ being transplanted? Yes No If YES, please select reason:

Primary organ defect caused damaged to a second organ and transplant of the primary organ will eliminate the disease

Damage to the second organ will compromise the outcome of the transplant of the primary organ

Additional Notes for Organ Transplant:

Please Note: If supporting documentation will be sent by mail or fax, please send the H&P, labs, imaging and treatment pertinent to the current admission ONLY. Sending the patient's entire medical record can cause delays in the processing of your request.