

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

FAX 1.844-633-8429 ORTHOTICS/PROSTHETICS

REGISTRATION ON C3 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 \_\_\_\_\_

Member Address, City, State, ZIP \_\_\_\_\_

Service Type:  ORTHOTICS  PROSTHETICS Place of Service: OFFICE

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 Request Type:  New  Repair  Replacement

## List ALL Relevant ICD Diagnosis Code(s):

Primary DX: \_\_\_\_\_ Symptoms: \_\_\_\_\_

**\*\*You may attach H&P or other relevant clinical documentation—if so, please write see attached\*\***

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

CPT/Service Code Requested: \_\_\_\_\_ Number of Units \_\_\_\_\_ Start Date \_\_\_\_\_

Circle Approximate Length of Time Needed: < 1 month 1-3 months 4-6 months 7-9 months 10-12 months Greater than 12

Circle Patient's Current Condition: Acute Chronic Long-Term Long-Term Maintenance (condition is stable) Terminal

CPT/Service Code Requested: \_\_\_\_\_ Number of Units \_\_\_\_\_ Start Date \_\_\_\_\_

Circle Approximate Length of Time Needed: < 1 month    1-3 months    4-6 months    7-9 months    10-12 months    Greater than 12

Circle Patient's Current Condition: Acute    Chronic    Long-Term    Long-Term Maintenance (condition is stable)    Terminal

Height: \_\_\_\_\_ Measurement  Centimeters     Inches

Weight: \_\_\_\_\_ Measurement  Kilos     Pounds    BMI: \_\_\_\_\_

Date Last Examined by Practitioner \_\_\_\_\_

Functional Level:  Level-0     Level-I     Level-II     Level-III     Level-IV

### **JUSTIFICATION OF MEDICAL NECESSITY**

Does Patient Have:

- Impaired Endurance                       Yes                       No
- Impaired Hearing                           Yes                       No
- Impaired Mobility                         Yes                       No
- Impaired Respiration                     Yes                       No
- Impaired Speech                          Yes                       No
- Impaired Vision                          Yes                       No
- Restricted Activity                        Yes                       No
- Skin Breakdown                          Yes                       No
- Require Assistance with ADL's         Yes                       No

NOTES:

Does the Patient and/or Caregiver demonstrate:

- Willingness and ability to use equipment     Yes                       No                       N/A
- Is item suitable for use in home?             Yes                       No                       N/A

Justification of Medical Necessity:

Are Physician's Order(s) Signed, Dated, and Attached?     Yes     No    Date of Order: \_\_\_\_\_

\*\*\*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

Have you attached the signed and dated Prescribing Practitioner Certification of Medical Necessity?     Yes     No

### **SUPPLIER/VENDOR INFORMATION**

Supplier Name \_\_\_\_\_ Supplier NPI \_\_\_\_\_

Supplier Contact Name \_\_\_\_\_

Supplier Phone Number: \_\_\_\_\_ Supplier Fax Number: \_\_\_\_\_

Supplier Address: \_\_\_\_\_

Supplier City, State, Zip: \_\_\_\_\_