

WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1-844-633-8430 PRIVATE DUTY NURSING

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: **PRIVATE DUTY NURSING**

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

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: T1000 Number of Units _____

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

PROGNOSIS

JUSTIFICATION OF MEDICAL NECESSITY

MEMBER IS MEDICALLY STABLE Yes No

VENTILATOR DEPENDENT Yes No

If yes, Ventilator hours per day _____

Does Patient Have:	Yes	No
Impaired Endurance		
Impaired Mobility		
Impaired Respiration		
Impaired Speech		
Restricted Activity		
Skin Breakdown		
Require Assistance with ADL's		
Caregiver Support Available		
Caregiver is available/willing to receive education necessary to provide services to the member		

Please include the following REQUIREMENTS:

Physician's Plan of Care
Private Duty Nursing Acuity Grid
Private Duty Nursing Home Psychosocial Grid

Caregiver Explanation if No:

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING CURRENT TREATMENT:

INTRAVENOUS FLUIDS/MEDICATIONS Yes No

If Yes: Type: _____ Dose: _____ Duration: _____ Frequency: _____

ENTERAL (TUBE) FEEDINGS Yes No

If yes, is this the sole source of nutrition? Yes No If Yes, Type of Nutrition: _____ Frequency: _____

OXYGEN Yes No LPM: _____ Hours per Day : _____

NON-VENTILATOR DEPENDENT TRACHEOSTOMY Yes No

PLEASE DESCRIBE FUNCTIONAL LIMITATIONS RELATED TO ADL:

PLEASE ANSWER THE FOLLOWING IF APPLICABLE:

- Occupational Therapy Weekly Bi-weekly Monthly Other
- Physical Therapy Weekly Bi-weekly Monthly Other
- Speech Therapy Weekly Bi-weekly Monthly Other
- Other Therapy Weekly Bi-weekly Monthly Other

DESCRIBE OTHER THERAPY AND FREQUENCY

PLEASE LIST OR ATTACH A MAR SHOWING NAME, STRENGTH, ROUTE, PRESCRIBED DATE, QUANTITY AND FREQUENCY:

ADDITIONAL ANNOTATION: