

# WV MEDICAID PRIOR AUTHORIZATION FORM

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

FAX 1-844-633-8431 PT/OT

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 \_\_\_\_\_

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

Procedure Type:  PT  OT Request Type:  Initial  Established

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:  Emergency/Medically Urgent  Non-Urgent Place of Service:  Office  OP Hospital

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

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

CPT Requested: \_\_\_\_\_ # OF UNITS \_\_\_\_\_ Start Date: \_\_\_\_\_  
CPT Requested: \_\_\_\_\_ # OF UNITS \_\_\_\_\_ Start Date: \_\_\_\_\_  
CPT Requested: \_\_\_\_\_ # OF UNITS \_\_\_\_\_ Start Date: \_\_\_\_\_

Are the physician orders for each code attached? \_\_\_ Yes \_\_\_ No If No, please list why:

**PERIOD OF REQUEST:**  30 days  60 days  90 days      **FREQUENCY OF VISITS:**  Biweekly  Monthly  Weekly

**DECLINING FREQUENCY EXPLANATION:** \_\_\_\_\_

**SUBJECTIVE COMPLAINTS:** \_\_\_\_\_

**PROGNOSIS:** \_\_\_\_\_

**OBJECTIVE FINDINGS:** \_\_\_\_\_

**EXTENUATING CIRCUMSTANCES:** \_\_\_\_\_

**HISTORY OF INJURY AND/OR SURGICAL PROCEDURE FOR CURRENT DIAGNOSIS:** \_\_\_\_\_

\_\_\_\_\_

**SHORT TERM GOALS + EXPECTED DATE MET** \_\_\_\_\_

\_\_\_\_\_

**LONG TERM GOALS + EXPECTED DATE MET** \_\_\_\_\_

\_\_\_\_\_

**HAVE NSAIDS BEEN USED?**  Yes  NO    If yes, duration:  0-3 months  3-6 months  6-9 months  9-12 months  +12 months

If yes list outcome: \_\_\_\_\_

If no list why: \_\_\_\_\_

**HAS ACTIVITY MODIFICATION BEEN TRIED?**  Yes  NO    If Yes, Length:  1-6 Weeks  7-12 Weeks  More than 12 Weeks

If yes list outcome: \_\_\_\_\_

If no list why: \_\_\_\_\_

**ADDITIONAL TREATMENT PLAN INFORMATION:**

- Chiropractic Services Utilized  Yes  NO
- Chiropractic Services Ongoing  Yes  NO
- Home Exercise Program Prescribed  Yes  NO
- Home Exercise Program Frequency  Daily  Every Other Day  3 Times per week or less  Other: \_\_\_\_\_
- Home Exercise Program Duration  1-6 Weeks  7-12 Weeks  More than 12 Weeks
- Home Exercise Program Outcomes: \_\_\_\_\_

**PLEASE INCLUDE THE FOLLOWING INFORMATION WITH SUBMISSION:**

- Signed & Dated Physicians Order for Each Requested Service
- Relevant Diagnostic Studies & Medication List
- Progress/Treatment Notes

NOTES: