

# WV MEDICAID PRIOR AUTHORIZATION FORM

FAX 1-844-633-8428 RADIOLOGY/RADIATION

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)

<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:  RADIOLOGY  RADIATION

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

Place of Service:  Office  Home  Mobile Unit  Urgent Care Facility  Inpatient Hospital  Outpatient Hospital  Emergency Room

Ambulatory Surgical Center  Birthing Center  Military Treatment Facility  Independent Clinic  Independent Lab

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

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

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

**CPT/Service Code(s) Requested:**

**START DATE** \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_ Are the physician orders for each code attached? \_\_\_Yes \_\_\_No If No, list why:

**Justification of Medical Necessity:**

**\*\*You may attach H&P and/or other relevant clinical documentation (i.e. previous diagnostic study results)—if so, please write see attached\*\***

**Current Course of Treatment**

**Conservative Treatment History** *To include Activity Modifications + NSAID trial—list duration & outcome for both or why not tried.*

**\*\*You may attach treatment plan—if so, please write see attached\*\***

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

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**Is this request pertaining to a Cancer Diagnosis?**  YES  NO

If Yes, Date of Diagnosis: \_\_\_\_\_

If Yes, Family History of Cancer:  YES  NO      Personal History of Cancer:  YES  NO

If Yes, Family Member with a known BRCA1/BRCA2 Mutation:  YES  NO

If Yes, Findings:

If Yes, Diagnosis Ruled Out:

If Yes, this service request is related to:

- Disease Progression       Metastasis       New Diagnosis       New Symptoms  
 Recurrence       Restaging       Treatment Planning

If Yes, Current Course of Treatment: