

WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1.844-633-8431 SPEECH

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 _____

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 Procedure: Emergency/Medically Urgent Non-Urgent PATIENT STATUS: New Established

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX: _____

****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

Please attach *Certificate of Medical Necessity* or appropriate documentation including signatures.

Service Code: Place of Service: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic	Service Code: Place of Service: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic	Service Code: Place of Service: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Rural Health Clinic
Units:	Units:	Units:
Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days
Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly
Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event

Declining Frequency Explanation:

REQUIRED WITH EACH SPEECH REQUEST

Certificate of Medical Necessity	Date of CMN _____
Signed Physician's Order(s)	Date of Order _____
Most Recent Progress Notes	Date of Notes _____
Waiver Letter for School-Aged Children	Date of Letter _____
Treatment Care Plan	Date of TCP _____
Members <21 Individual Education Plan	Date of IEP _____
Progress Notes for Past Treatments	Date of PN _____
Short and Long Term Goals	Date of Goals _____

For renewal of speech services progress notes and new goals are always required.

NOTES:

ATTACHED?

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No