

WV MEDICAL ATREZZO PROVIDER PORTAL PRIOR AUTHORIZATIONS

PLEASE INDICATE THE INTENDED RECIPIENT AND FAX TO THE CORRESPONDING NUMBER

- | | | |
|--|---|--|
| <input type="checkbox"/> 1.844.633.8426
INPATIENT (ACUTE)
INPATIENT REHAB
ORGAN TRANSPLANTS
INPATIENT SURGERY | <input type="checkbox"/> 1.844.633.8428
RADIOLOGY/RADIATION/LAB/
GENETIC TESTING | <input type="checkbox"/> 1.844.633.8430
HOSPICE/HOME HEALTH
PRIVATE DUTY NURSING |
| <input type="checkbox"/> 1.844.633.8427
OUTPATIENT SURGERY
PHYSICIAN ADMINSTERED
DRUGS | <input type="checkbox"/> 1.844.633.8429
DME
ORTHOTICS & PROSTHETICS
CARDIAC/PULMONARY REHAB | <input type="checkbox"/> 1.844.633.8431
SPEECH/AUDIOLOGY
PT/OT
DENTAL/ORTHODONTIC
VISION
PODIATRY
CHIROPRATIC |

Date:	
Member Name:	Member Medicaid ID:
Authorization Request ID: (from ATREZZO Provider Portal)	
Please mark the following Request Type:	<input type="checkbox"/> ORIGINAL <input type="checkbox"/> RECONSIDERATION
COMMENT:	

Submitting ATREZZO Org:	
Provider Name & Provider ID:	
Contact Name:	
Provider Telephone:	Provider Facsimile:

CONFIDENTIALITY NOTICE

Warning: Unauthorized interception of this telephonic communication could be a violation of Federal Law the documents accompanying this telecopy contain confidential information belonging to the sender which is legally privileged. The information is intended only for use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of the tele-copied information is strictly prohibited. If you have received this telecopy in error, please immediately notify us to arrange the return of the original documents to Acentra Health at (800) 346.8272 or email: wvmedicalservices@acentra.com.

ENCLOSED SUPPORTING DOCUMENTATION IS AS FOLLOWS: # OF PAGES _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Plan of Care/Treatment Plan | <input type="checkbox"/> Explanation of Benefits (EOB) | <input type="checkbox"/> Release of Information |
| <input type="checkbox"/> Dental X-Rays/Radiographs/Molds | <input type="checkbox"/> Cost Calculation | <input type="checkbox"/> Prescription/Practitioner's Order
(signed/dated within the last 6 months) |
| <input type="checkbox"/> Labs/Diagnostic Test Results | <input type="checkbox"/> Certificate of medical necessity (CMN) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Treatment Notes/Progress Notes | <input type="checkbox"/> Medication Administration Record (MAR) | |
| <input type="checkbox"/> Appeal Document | <input type="checkbox"/> OASIS (Home Health/PDN) | |
| <input type="checkbox"/> Signature Page(s)/Certifications | <input type="checkbox"/> History and Physical | |

<https://atrezzo.acentra.com/>