

CONFIDENTIAL SUPPORTING DOCUMENTATION FOR EXISTING ATREZZO PROVIDER PORTAL CASE



WVCHIP 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 UNDER 21
ORGAN TRANSPLANTS
INPATIENT SURGERY | <input type="checkbox"/> 1.844.633.8428
IMAGING/RADIOLOGY/LAB

<input type="checkbox"/> 1.844.633.8429
DME
ORTHOTICS & PROSTHETICS
CARDIAC/PULMONARY REHAB | <input type="checkbox"/> 1.844.633.8430
HOSPICE/HOME HEALTH
PRIVATE DUTY NURSING

<input type="checkbox"/> 1.844.633.8431
SPEECH/AUDIOLOGY
PT/OT
DENTAL/ORTHODONTIC
VISION
PODIATRY
CHIROPRACTIC |
|---|--|--|

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

Submitting C3 Org:	
Provider Name & Provider ID:	
Contact Name:	
Provider Telephone:	Provider Facsimile:

CONFIDENTIALITY NOTICE

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ENCLOSED SUPPORTING DOCUMENTATION IS AS FOLLOWS:

OF PAGES _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Plan of Care/Treatment Plan
<input type="checkbox"/> Dental Molds
<input type="checkbox"/> Labs/Diagnostic Test Results
<input type="checkbox"/> Treatment Notes/Progress Notes
<input type="checkbox"/> Referral/Authorization Request
<input type="checkbox"/> X-Rays/Radiographs | <input type="checkbox"/> Signature Page(s)/Certifications
<input type="checkbox"/> Certificate of medical necessity (CMN)
<input type="checkbox"/> Medication Administration Record (MAR)
<input type="checkbox"/> OASIS (Home Health/PDN)
<input type="checkbox"/> History and Physical | <input type="checkbox"/> Prescription/Practitioner's Order
(signed/dated within the last 6 months)

<input type="checkbox"/> Other (specify): _____ |
|---|--|--|