**WEST VIRGINIA SENIOR ADVANTAGE PRIOR AUTHORIZATION REQUEST**

**COMPLETE ALL INFORMATION ON THIS REQUEST—INCOMPLETE SUBMISSIONS WILL NOT BE PROCESSED**

**AN AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT AND IS ONLY FOR THE SERVICES INDICATED BELOW. PAYMENT IS SUBJECT TO THE LIMATIONS AND EXCLUSIONS AS OUTLINED IN THE MEMBER EVIDENCE OF COVERAGE.**

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| **PROVIDER INFORMATION (\*Denotes Required Field)** | | | | |
| **\*Requesting Provider Name:**  **\*Requesting Provider NPI:** | | **\*As the requesting provider, are you currently contracted as an in-network participating provider with WVSA?**  **Circle: YES or NO**  **\*Is the rendering provider a contracted participating in-network provider with WVSA?**  **Circle: YES or NO** | | **\*Name of Person Completing this Form:**  **\*Phone#:**  **\*Fax#:** |
| **\*Rendering Provider-Specialist/Facility Name:**  **Same as Requesting Provider**  **\*Rendering Provider-Specialist/Facility NPI:** | | **\*Rendering Provider Address:**  **\*Rendering Provider-Specialist/Facility Tax-ID:** | | **\*Signature of Person Completing this Form:**  **\*Date:** |
| **CIRCLE THE SERVICE TYPE REQUIRING A PRIOR AUTHORIZATION** | | | | |
| **Inpatient Care/Observation:**  **Acute Medical/Surgical**  **Long-Term Care Acute**  **Skilled Nursing Facility**  **Observation**  **Behavioral Health Services** | | **Durable Medical Equipment/Supplies:**  **Prosthetic Device**  **Purchase**  **Rental**  **Renal Supplies**  **Hearing Devices** | | **OUT-OF-NETWORK (OON)**  **All (OON) services require prior authorization**  **Specialist Consult**  **Recommended Specialist Treatment**  **IP Services**  **Ambulatory/Outpatient Surgery**  **Infusion or Oncology Therapy**  **Diagnostic Testing**  **Imaging**  **Dialysis**  **\*Non-Emergent Ground Transportation**  **\*Non-Emergent Air Transportation**  **Durable Medical Equipment & Supplies**  **Behavioral Health Services**  **Specify Other:** |
| **Transportation:**  **\*Transportation requests MUST be completed on the WVSA NEMT FORM effective January 1, 2021.**  **Non-Emergent Ground**  ***List Destination*:**  **Non-Emergent Air**  ***List Destination*:** | | **Specify Other:** | |
| **Substance Abuse Services**  **List Treatment:** | | **Please attach all supporting orders and clinical documentation with this request.** | |
| **MEMBER INFORMATION (\*DENOTES REQUIRED FIELD)** | | | | |
| **\*Member Name:** | | **\*Member ID#:**  **\*Member DOB:** | | **\*Member Place of Residency (SNF):** |
| **DIAGNOSIS/PLANNED PROCEDURE INFORMATION (\*DENOTES REQUIRED FIELD)** | | | | |
| **\*PRINCIPAL ICD-10 CODES:**  **\*PRINCIPAL DIAGNOSIS DESCRIPTION:** | | | **PRINCIPAL PLANNED PROCEDURE**  **\*CPT/HCPCS CODES:**  **\*DESCRIPTION:**  **\*SERVICE START DATE: \*SERVICE END DATE:** | |
| **SECONDARY ICD-10 CODES:**  **SECONDARY DIAGNOSIS DESCRIPTION:** | | | **SECONDARY PLANNED PROCEDURE**  **\*CPT/HCPCS CODES:**  **\*DESCRIPTION:**  **\*SERVICE STARTE DATE: \*SERVICE END DATE:** | |
| **Is this an Expedited Request?**  **Waiting for a decision under the standard time could place the member’s life, health or ability to gain maximum function is in serious jeopardy.**  **INITIAL HERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Is this a Standard Request?**  **CMS allow 14-days to authorize.** | | **FAX THIS FORM TO: 1-813-472-7429**  **FOR QUESTIONS CALL: 1-844-854-6888** | |