**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** |