**WEST VIRGINIA SENIOR ADVANTAGE NEMT AUTHORIZATION REQUEST**

**COMPLETE ALL INFORMATION ON THIS PRIOR AUTHORIZATION 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/Rendering NEMT Provider Name:** | **\*As the requesting/rendering NEMT provider, are you currently contracted as an in-network participating provider with WVSA?****Circle: YES or NO** | **\*Name of Person Completing this Form:****\*Phone#:****\*Fax#:** |
| **\*Requesting/Rendering NEMT Provider NPI:****\*Rendering Provider-Specialist/Facility Tax-ID:** | **\*Rendering NEMT Provider Address:** | **\*Signature of Person Completing this Form:****\*Date:** |
| **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 REQUIRING NEMT****\*CPT/HCPCS CODES:****\*DESCRIPTION:** **\*SERVICE START DATE: \*SERVICE END DATE:****\*RENDERING PROVIDER:****\*RENDERING PROVIDER ADDRESS:** |
| **SECONDARY ICD-10 CODES:****SECONDARY DIAGNOSIS DESCRIPTION:** |
| **MEDICAL NECESSITY (\*Denotes Required Field)** |
| **\*Are all other means of transport contraindicated?** |  **YES*****If “YES” please complete the remainder of this form*** |  **NO*****If “NO” this member does not qualify for NEMT*** |
| **\*How does the member transfer?****Assisted Unassisted** | **\*Does the member pose immediate** **danger to self or others?****YES NO** | **\*Is the member morbidly obese?****YES NO****Member Weight (pounds): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\*Is the member bed-confined?****(unable to sit in a chair, stand, or ambulate)****YES NO** | **\*If not bed-confined, does the member use an assistive walking device?****YES NO** |
| **\*Member Mobility Level:****\_\_\_\_Ambulatory****\_\_\_\_Unable to Ambulate****\_\_\_\_Wheelchair dependent****\_\_\_\_Unable to transfer safely from wheelchair****\_\_\_\_Cannot be safely transported by private car****\_\_\_\_Must remain immobile (i.e. fracture, etc.)****\_\_\_\_List Other:** | **\*Member requires monitoring by trained staff due to:****\_\_\_\_Oxygen (portable O2 does not apply)****\_\_\_\_Airway****\_\_\_\_Suction****\_\_\_\_Hyperbaric Therapy****\_\_\_\_Advanced Decubitus Ulcers****\_\_\_\_Contractures limiting Mobility****\_\_\_\_Decreased sitting tolerance time or balance****\_\_\_\_Active Seizures****\_\_\_\_Must remain immobile (i.e. fracture, etc.)****\_\_\_List Other:****\_\_\_\_Comatose****\_\_\_\_Cardiac****\_\_\_\_Life Support****\_\_\_\_Behavioral****\_\_\_\_Continuous IV Therapy****\_\_\_\_Enteral/Parenteral Feedings****\_\_\_\_Wound Precautions****\_\_\_\_Isolation Precautions for active infection** |
| **Please attach all supporting orders and clinical documentation with this request to support all conditions requiring transport by ambulance.** |
| **REQUEST TYPE** |
| **\*List reason for transport:** | **\*Is this a hospital discharge?****YES NO****\*Date of Discharge:** **List Address:** | **\*Traveling From** (origin)\_\_\_Acute Care Hospital\_\_\_Long-Term Acute Care\_\_\_Inpatient Rehab\_\_\_Inpatient Hospice\_\_\_Skilled Nursing Facility \_\_\_Dialysis Facility\_\_\_OP Clinic\_\_\_Physician’s Office\_\_\_Member’s HomeList Other: | **\*Traveling To (**destination)\_\_\_Acute Care Hospital\_\_\_Long-Term Acute Care\_\_\_Inpatient Rehab\_\_\_Inpatient Hospice\_\_\_Skilled Nursing Facility \_\_\_Dialysis Facility\_\_\_OP Clinic\_\_\_Physician’s Office\_\_\_Member’s HomeList Other: |
| **\*Method of transport:****\_\_\_\_Ground****\_\_\_\_Fixed Wing****\_\_\_\_Helicopter****\_\_\_\_Specialized** |
| **\*Is this a One-Time, nonrepeating transport?****YES NO** | **\*Is this a Recurring transport?****YES NO** |
| **\*Is this a scheduled Round-Trip?****YES NO** | **\*Estimated Number of Trips Requested (2-60):** |
| **\*Frequency of Transports:** |
| **\*Type of Transport:****\_\_\_\_A0426: ALS1—advanced life support, NEMT****\_\_\_\_A0428: BLS1—basic life support, NEMT****\_\_\_\_A0130: ALS1—NEMT** | **\*Reason for Recurring transport (2-60 day):****\_\_\_\_Dialysis****\_\_\_\_Radiation Therapy****\_\_\_\_Hyperbaric Therapy****\_\_\_\_Wound Care****\_\_\_\_List Other:** | **NO PRIOR AUTHORIZATION REQUIRED FOR****EMERGENT TRANSPORTS** |
| **NOTES:** |
|  **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**  |
| **If the member does not attend the scheduled appointment, please contact WVSA** **to make the appropriate changes.**  |