**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 Home  List 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 Home  List 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.** | | | |