**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:****Fax#:** | **\*Rendering Provider Address:****\*Rendering Provider-Specialist/Facility Tax-ID:** | **\*Signature of Person Completing this Form:****\*Date:** |
| **CIRCLE/LIST THE SERVICE TYPE REQUIRING A PRIOR AUTHORIZATION** **Please attach all supporting orders and clinical documentation with this request.** |
| **Circle Elective Inpatient (IP) Care:****Acute Medical IP****Elective/Scheduled IP Surgical****Elective/Scheduled IP Procedure****Long-Term Acute Care (LTAC)****IP Mental Health Services****Partial IP Hospitalization** **\*Observation and Emergency Services require notification to the health plan.** | **Circle & List Durable Medical Equipment/Supplies:****DME****Prosthetic/Orthotic Device****Renal Supplies****Specify Other:** | **ALL OUT-OF-NETWORK SERVICES REQUIRE** **PRIOR AUTHORIZATION****List:** |
| **Circle & List Outpatient Service:****Diagnostic Imaging\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Diagnostic Lab\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Diagnostic Test/Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****OP Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Specify Other:** |
| **Home Health** |
| **Hearing Devices****\*Beyond meeting medical necessity criteria, verification of $1800 biennial benefit for each member is also required.**  | **Part B Rx Services/Home Infusions** |
| **Chemotherapy****\*Only the Initial round of Chemotherapy requires authorization.** |
| **Mental Health Specialty Services** | **Circle Dialysis: Hemodialysis Peritoneal** |
| **Substance Use Disorder Services** | **Chiropractic** |
| **Circle Outpatient Rehabilitation Services:****Occupational Therapy** **Physical Therapy** **Speech Therapy** | **Opioid Treatment Services** | **\*NEMT GROUND/AIR TRANSPORTATION** **REQUESTS MUST BE COMPLETED ON THE WVSA NEMT FORM EFFECTIVE 1/1/2021.** |
| **Cardiac/Pulmonary Rehabilitation** |
| **Specify Other:** |
| **MEMBER INFORMATION (\*DENOTES REQUIRED FIELD)** |
| **\*Member Name:** | **\*Member ID#:****\*Member DOB:** | **\*Member Place of Residency (list SNF):** |
| **DIAGNOSIS/PLANNED PROCEDURE INFORMATION (\*DENOTES REQUIRED FIELD)** |
| **\*PRINCIPAL ICD-10 CODES:****\*PRINCIPAL DIAGNOSIS DESCRIPTION:** **SECONDARY ICD-10 CODES:****SECONDARY DIAGNOSIS DESCRIPTION:** | **\*PLANNED PROCEDURE CPT/HCPCS CODES:****\*DESCRIPTION:** **\*SERVICE START DATE: \*SERVICE END DATE:** |
| **Is this a recurring service? Circle: YES or NO If yes, list the number of units/visits/treatments requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_Dialysis \_\_\_\_Radiation Therapy \_\_\_\_Hyperbaric Therapy \_\_\_\_Wound Care \_\_\_\_List Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\**Orders must reflect recurring and number of units/visits/treatment.*****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?*****Note: CMS allows up to 14-days for determinations.***  | **FAX THIS FORM TO: 1-813-472-7429****FOR QUESTIONS CALL: 1-844-854-6888** |

**WVSA Prior Authorization Request V4.2021D**