**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.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**