**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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| **MEMBER INFORMATION (\*DENOTES REQUIRED FIELD)** | | | |
| **\*Member Name:** | **\*Member ID#:**  **\*Member DOB:** | | **\*Member Place of Residency (SNF):** |
| **CIRCLE THE SERVICE TYPE REQUIRING A PRIOR AUTHORIZATION (\*DENOTES REQUIRED FIELD)**  **ALL OUT-OF-NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION** | | | |
| **Acute Medical Inpatient**  **Elective/Scheduled Inpatient Surgical**  **Elective/Scheduled Inpatient Procedure**  **Long-Term Acute Care (LTAC)**  **Inpatient Mental Health Services**  **Partial Inpatient Hospitalization**  **\*Observation and Emergency Services only require notification to the health plan**  **NEMT (non-emergency medical transport)**  **\*COMPLETE PAGE 2 FOR NEMT—REQUIRED** | **Outpatient Diagnostic Imaging**  **Outpatient Diagnostic Lab**  **Outpatient Diagnostic Test/Procedure**  **Outpatient Surgery**  **Outpatient Occupational Therapy**  **Outpatient Physical Therapy**  **Outpatient Speech Therapy**  **Outpatient Cardiac/Pulmonary**  **Chiropractic**  **Dialysis**  **Part B Rx Services/Home Infusions**  **Chemotherapy** | | **Home Health**  **Mental Health Specialty Services**  **Substance Use Disorder Services**  **Opioid Treatment Services**  **DME**  **Prosthetic**  **Orthotic**  **Hearing Devices**  **\* Please verify annual benefit for member is available**  **Eyeglasses (only for out-of-network)**  **\*Please verify annual benefit for member is available**  **Specify Other:**  **.** |
| **\*ICD-10 CODES:**  **\*DIAGNOSIS DESCRIPTION:**  **Please attach all supporting orders and clinical documentation with this request.** | | | |
| **\*PRINCIPAL PLANNED PROCEDURE(S) CPT/HCPCS CODES:**  **\*DESCRIPTION:**  **\*SERVICE START DATE: \*SERVICE END DATE:** | | | |
| **PROVIDER INFORMATION (\*DENOTES REQUIRED FIELD)** | | | |
| **\*Requesting Provider Name: \*Requesting Provider NPI:**    **\*Ordering Provider Name: \*Ordering Provider NPI:**  **\*Rendering Provider-Specialist/Facility Name: \*Rendering Provider-Specialist/Facility NPI:**  **\*Specialty of Rendering Provider: \*Rendering Provider-Specialist/Facility FAX:**  **\*Rendering Provider Service Location Address: \*Rendering Provider-Specialist/Facility PHONE:** | | | |
| **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.** | **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** | |
| **\*Name of Person Completing this Form:** | **\*Phone#:** | **\*Fax#:** | |

**WEST VIRGINIA SENIOR ADVANTAGE TRANSPORTATION DOCUMENTATION**

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| **NON-EMERGENCY MEDICAL TRANSPORT (NEMT) MEDICAL NECESSITY CERTIFICATION (\*Denotes Required Field)** | | | |
| **\*Are all other means of transport contraindicated?**  **YES NO**  ***If “YES” please complete the remainder of this form***  ***If “NO” this member does not qualify for NEMT*** | **\*Is the member morbidly obese?**  **YES NO**  **Member Weight:** | **\*List Transport CPT/HCPCS CODES + MODIFIERS:** | |
| **\*How does the member transfer?**  **Assisted Unassisted** | **\*Does the member pose immediate danger to self or others?**  **YES NO** | **\*ICD-10 CODES deeming NEMT necessary:**  **Please attach all supporting orders and clinical documentation with this request to support all conditions requiring transport by ambulance.** | |
| **\*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** |
| **\*Circle 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:** | **\*Circle reason for transport:**  **Hospital discharge**  **Specialist Appointment**  **Dialysis**  **OP Diagnostic Service**  **OP Treatment**  **IP Scheduled Procedure**  **List Other:**  **\*List Destination Address:**  **\*List Estimated Mileage:**  **\*Frequency of Transports:** | **\*Traveling From (origin)**  **CIRCLE Place of Service (POS)**  **Physician’s Office (11)**  **Inpatient Hospital (21)**  **IP Psychiatric Facility (51)**  **OP Hospital OFF campus (19)**  **OP Hospital ON campus (19)**  **ESRD Dialysis Facility (65)**  **Ambulatory Surgical Center (24)**  **Long-Term Acute Care (11)**  **Inpatient Rehab (61)**  **Outpatient Rehab (62)**  **Hospice (34)**  **Skilled Nursing Facility (31)**  **Nursing Facility (32)**  **Custodial Care (33)**  **Member’s Home (12)**  **Community Mental Health (53)**  **Residential Substance Use Fac (55)**  **Non-Residential Substance Use Fac (57)**  **Non-Residential Opioid Treatment (58)**  **Mass Immunization Center (60)**  **Public Health Clinic (71)**  **FQHC (50)**  **Rural Health Clinic (72)**  **Independent Clinic (49)**  **Independent Lab (81)**  **Military Treatment Facility (26)**  **Urgent Care Facility (20)**  **List Other:**  **NO PRIOR AUTHORIZATION REQUIRED FOR**  **EMERGENT TRANSPORTS** | **\*Traveling To (destination)**  **CIRCLE Place of Service (POS)**  **Physician’s Office (11)**  **Inpatient Hospital (21)**  **IP Psychiatric Facility (51)**  **OP Hospital OFF campus (19)**  **OP Hospital ON campus (19)**  **ESRD Dialysis Facility (65)**  **Ambulatory Surgical Center (24)**  **Long-Term Acute Care (11)**  **Inpatient Rehab (61)**  **Outpatient Rehab (62)**  **Hospice (34)**  **Skilled Nursing Facility (31)**  **Nursing Facility (32)**  **Custodial Care (33)**  **Member’s Home (12)**  **Community Mental Health (53)**  **Residential Substance Use Fac (55)**  **Non-Residential Substance Use Fac (57)**  **Non-Residential Opioid Treatment (58)**  **Mass Immunization Center (60)**  **Public Health Clinic (71)**  **FQHC (50)**  **Rural Health Clinic (72)**  **Independent Clinic (49)**  **Independent Lab (81)**  **Military Treatment Facility (26)**  **Urgent Care Facility (20)**  **List Other:**  **FAX THIS FORM TO: 1-813-472-7429**  **FOR QUESTIONS CALL: 1-844-854-6888** |
| **\*Circle member continuous monitoring needs:**  **Oxygen (portable O2 does not apply)**  **Airway**  **Suction**  **Hyperbaric Therapy**  **Comatose**  **Cardiac**  **Life Support**  **Behavioral**  **Continuous IV Therapy**  **Enteral/Parenteral Feedings**  **Wound Precautions**  **Isolation Precautions for active infection**  **Advanced Decubitus Ulcers**  **Contractures limiting Mobility**  **Decreased sitting tolerance time or balance**  **Active Seizures**  **Must remain immobile (i.e. fracture, etc.)**  **List Other:** |
| **\*Circle method of transport:**  **Ground**  **Fixed Wing**  **Helicopter**  **Specialized**  **List Other:** |
| **\*Circe one:**  **One-Time, nonrecurring NEMT request?**  **Recurring, NEMT transport request?** | **\*Circe one:**  **One-Way Trip Request?**  **Round-Trip Request?** |
| **\*Circle reason for Recurring transport:**  **Dialysis**  **Radiation Therapy**  **Hyperbaric Therapy**  **Wound Care**  **List Other:** | **\*Number of Recurring Trips Requested:** |
| ***WVSA follows all CMS Medicare Benefit Policy Manual Chapter 10–Ambulance Services guidelines*** | | |