**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*** |