AUTHORIZATION SUBMISSION FAX: 813-472-7429

West Virginia Senior Advantage

REQUEST FOR AUTHORIZATION OF SERVICES

PARTICIPATING PROVIDERS: Please refer to Section III for the list of services that require prior authorization.
NON-PARTICIPATING PROVIDERS: Prior authorization is required for all services with exception of emergent, urgent care, and observation. An authorization is not a guarantee of payment and is only for the services indicated below. Payment is subject to the limitations and exclusions as outlined in the Member Evidence of Coverage.

Section I: Member Information

Member Name: _____ Date of Birth: _____ Member ID: _____

Ordering Provider: _____ Phone No.: _____ Fax No.: _____

Primary Diagnosis (ICD-10 and Description): _____

Reason for Service Request: _____

Section II: Requesting Provider/Requesting Facility Information

Rendering Facility Name _____ Street Address _____

Facility Phone _____ City, ST, ZIP _____

Facility Fax _____ Facility NPI _____ Facility Tax ID _____

Rendering Provider Name _____ Street Address _____

Provider Phone _____ City, ST, ZIP _____

Provider NPI _____ Provider Tax ID _____

Section III: Services Requested (include copy of order or clinical note)

Start Date: _____ End Date: _____

- ☐ Abortion
- ☐ Acute Rehabilitation Facility
- ☐ Air Ambulance
- ☐ Ambulatory Surgery Center
- ☐ Behavioral Health
  - ☐ Inpatient
  - ☐ Partial Hospital
  - ☐ Neurological Testing
  - ☐ Psychological Testing
- ☐ Chemotherapy (>$1,000) (injectable drugs)
- ☐ Clinical Trials (not approved by Medicare)
- ☐ Dental Services
- ☐ DME (>$1,000)
- ☐ Enteral/Parenteral Feeding (>$1,000)
- ☐ Experimental/Investigational Procedures
- ☐ Genetic Testing
- ☐ Home Health Services
- ☐ Hospice (Notification Only)
- ☐ Hospital – Inpatient
- ☐ Hospital – Outpatient Surgery
- ☐ Hospital – Long-Term Acute Care
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable Pump, Device, Stimulator
- ☐ Infusion Therapy
- ☐ Medical Nutrition Education
- ☐ Medical supplies (>$1,000) (except diabetic supplies)
- ☐ MOHS Procedure (Dermatology)
- ☐ **Non-Participating Provider**
- ☐ Opioid Treatment
- ☐ Outpatient Hospital (excludes labs, ultrasounds, x-rays)
- ☐ Pain Management
- ☐ Part B Drugs (>$1,000)
- ☐ Prosthetics/Orthotics (>$1,000)
- ☐ Radiation Therapy/Radiation Oncology
- ☐ Radiology/Diagnostic Test: Cardiac, CT, CTA, Echo, MRA, MRI, Nuclear Med, PET, Pill, MUGA, Medical Oncology, Virtual Colonoscopy or Endoscopy and 3-D Ultrasounds
- ☐ Rehab Therapy: PT, OT, ST, Outpatient, and Office
- ☐ Rehab: Cardiac/Pulmonary/Respiratory
- ☐ Skilled Nursing Facility
- ☐ Sleep Study
- ☐ Sterilization
- ☐ TMJ Treatment
- ☐ Transplant
- ☐ Wound Care (outpatient hospital only)

REQUEST FOR AUTHORIZATION OF SERVICES, continued

CPT or HCPC Code(s)	Description	# of Visits/Injections

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization**: Authorizations will be processed within 14 days of receipt.

☐ **Expedited Authorization (Must Read and SIGN)**: By signing below, I certify that waiting for a decision under the standard time frame could place the Member's life or health in serious jeopardy.

SIGNATURE:

Name of Person Completing this Form:

Date Completed:

Contact #:

Authorization Notification Fax:

To check on the status of an authorization or for other questions, please call 844-854-6888.

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.