WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1.844-633-8431 VISION <21**

REGISTRATION ON ATTREZO IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON https://portal.kepro.com/

ATTREZO Requesting/Submitting Organization _____Please list exactly as registered on ATREZZO

Address, City, State, Zip _____

ATTREZO Requesting/Submitting Organization NPI _____ Please list exactly as registered on ATTREZO

Person Submitting Request _____ **Phone** _____ **Fax** _____ **Email**_____

Referring/Ordering Provider

(Per policy the Referring/Ordering Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**	
Contact Information	**Phone**	**Fax:**

Place of Service/Servicing Provider

(Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**
Address, City, State, Zip	

Member Medicaid Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Authorization Type: ☐**Prior Authorization** **Place of Service: OFFICE**

☐**Retrospective Request, if applicable list the appropriate reason:**

☐**Denied by Member's Primary Payer** ☐**Retrospective Medicaid Eligibility**

List Other Retro Reason:

For Members under age 21, is this request an EPSDT referral? ☐**Yes** ☐**NO** ****If yes, please submit the most current EPSDT form on file****

Type of Admission/Procedure: ☐**Emergency/Medically Urgent** ☐**Non-Urgent** **Date of Last Vision Exam: _____**

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

92326	**REPLACEMENT OF CONTACTS LENS**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92065	**ORTHOPTIC/PLEOPTIC TRAINING**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____
92134	**SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; RETINA**	POS: 11 OFFICE # of Units: 1 Start Date:_____/_____/_____

IF THIS IS A REPAIR OR REPLACEMENT REQUEST PLEASE ANSWER THE FOLLOWING QUESTION:

- **HAS VISUAL APPLIANCE BEEN REPAIRED OR REPLACED WITHIN THE PAST YEAR?** ☐**Yes** ☐**NO**
- **IF YES, PLEASE INDICATE HOW MANY TIMES VISUAL APPLIANCES HAVE BEEN REPAIRED OR REPLACED.**
  - **PLEASE INDICATE NUMBER OF TIMES:** _____

ADDITIONAL ANNOTATIONS: