CONFIDENTIAL SUPPORTING DOCUMENTATION FOR EXISTING ATREZZO PROVIDER PORTAL CASE

WV MEDICAL ATREZZO PROVIDER PORTAL PRIOR AUTHORIZATIONS

PLEASE INDICATE THE INTENDED RECIPIENT AND FAX TO THE CORRESPONDING NUMBER

☐ **1.844.633.8426**
INPATIENT (ACUTE)
INPATIENT REHAB UNDER 21
ORGAN TRANSPLANTS
INPATIENT SURGERY

☐ **1.844.633.8427**
OUTPATIENT SURGERY
PHYSICIAN ADMINSTERED DRUGS

☐ **1.844.633.8428**
RADIOLOGY/RADIATION/LAB/ GENETIC TESTING

☐ **1.844.633.8429**
DME
ORTHOTICS & PROSTHETICS
CARDIAC/PULMONARY REHAB

☐ **1.844.633.8430**
HOSPICE/HOME HEALTH
PRIVATE DUTY NURSING

☐ **1.844.633.8431**
SPEECH/AUDIOLOGY
PT/OT
DENTAL/ORTHODONTIC
VISION
PODIATRY
CHIROPRATIC

Date:	
Member Name:	**Member Medicaid ID:**
Authorization Request ID: (from ATREZZO Provider Portal)	
Please mark the following Request Type:	☐ **ORIGINAL** ☐ **RECONSIDERATION**
COMMENT:	

Submitting ATREZZO Org:	
Provider Name & Provider ID:	
Contact Name:	
Provider Telephone:	**Provider Facsimile:**

CONFIDENTIALITY NOTICE

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ENCLOSED SUPPORTING DOCUMENTATION IS AS FOLLOWS: # OF PAGES_____

☐ **Plan of Care/Treatment Plan**
☐ **Dental X-Rays/Radiographs/Molds**
☐ **Labs/Diagnostic Test Results**
☐ **Treatment Notes/Progress Notes**
☐ **Appeal Document**
☐ **Signature Page(s)/Certifications**
☐ **Explanation of Benefits (EOB)**
☐ **Cost Calculation**
☐ **Certificate of medical necessity (CMN)**
☐ **Medication Administration Record (MAR)**
☐ **OASIS (Home Health/PDN)**
☐ **History and Physical**
☐ **Release of Information**
☐ **Prescription/Practitioner's Order (signed/dated within the last 6 months)**
☐ **Other (specify):** _____

https://portal.kepro.com/