



WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1.844-633-8431 AUDIOLOGY

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 ATTREZZO
Address, City, State, Zip _____

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

Person Submitting Request _____ Phone _____ Fax _____ Email _____

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

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

Place of Service/Service Provider (Per policy the Place of Service/Service Provider must be actively enrolled with WVCHIP)

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

Member WVCHIP Number _____ DOB _____

Member First Name _____ Last Name _____

Member Address, City, State, ZIP _____

Procedure Type: **AUDIOLOGY** PATIENT STATUS: New Established

Authorization Type: Prior Authorization

Retrospective WVCHIP Eligibility

Retrospective Request, if applicable list the appropriate reason:

List Other Retro Reason:

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent Place of Service: OFFICE

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other: _____

Type of Hearing Loss: Conductive Mixed Sensorineural

Severity of Hearing Loss:

Left Ear No Hearing Impairment Mild 25-40 dB HL Moderate 41-70 dB HL Severe 71-90 dB HL Profound >91 dB HL dB
Right Ear No Hearing Impairment Mild 25-40 dB HL Moderate 41-70 dB HL Severe 71-90 dB HL Profound >91 dB HL dB

SERVICE SELECTION

Service Code:	Service Code:	Service Code:
Units:	Units:	Units:
Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days	Period of Request: <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days
Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly	Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly
Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event	Duration of Individual Therapy Services: <input type="checkbox"/> 1 hour <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Event

Declining Frequency of Visits Explanation: _____

Does member have an Individual Education Plan (IEP) that includes these services? Yes No If yes, please attach a copy.

I certify that this patient meets the program eligibility criteria and that this equipment is a part of the course of treatment and is reasonable, medically necessary and is most cost effective and is not a convenience item for the recipient, family, attending practitioner or supplier. To my knowledge, the above information is accurate. Yes No Please attach certificate of Medical Necessity or appropriate documentation including signatures.

Medical History: Please include prior use of hearing aids and other intervention services. *You may include clinical documentation—write see attached*****

Date of Medical Examination: _____ **(INCLUDE ALL RELEVANT DIAGNOSTIC STUDY RESULTS, MEDICATIONS, EXAM FINDINGS)**

2 _____
Medical Examination Findings:

Date of Most Recent Audiological Evaluation (Required): _____ Attached? Yes No

Date of Most Recent Audiologist Treatment Care Plan (Required): _____ Attached? Yes No

Date of Most Recent Signed/Dated Physician Order (Required): _____ Attached? Yes No

Have you attached the required COST INVOICE and COST CALCULATION FORM if selecting a hearing aid code? Yes No

Date of Cochlear Implant Placement: _____
Reason for Cochlear Implant Replacement

Date of Cochlear Implant Repair: _____
Reason for Cochlear Implant Repair

PLEASE PROVIDE AUDIOLOGY DEVICE INFORMATION:

Make/Model: _____

Expiration Date : _____

Date of Placement: _____

Success: _____

Date of Warranty: _____

NOTES: