WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8429 DME**

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 WVCHIP)

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 WVCHIP)

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

Member WVCHIP Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Procedure Type: DME **Type of Admission/Procedure:** ☐**Emergency/Medically Urgent** ☐**Non-Urgent**

Authorization Type: ☐**Prior Authorization** ☐**Retrospective WVCHIP Eligibility**

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

Request Type: ☐**New** ☐**Repair** ☐**Replacement**

Length of Time Needed: ☐**Days** ☐**Months** ☐**Ongoing** ☐**Permanent** ☐**Weeks** ☐**Years**

List Other Retrospective Reason:

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

DOCUMENTS TO BE SUBMITTED:

- **Certificate of Medical Necessity** **Date of CMN** _____ **Yes** **No**
- **Signed Physician's Order(s)** **Date of Order** _____ **Yes** **No**
- **Most Recent Progress Notes** **Date of Notes** _____ **Yes** **No** **N/A**
- **Waiver Letter for School-Aged Children** **Date of Letter** _____ **Yes** **No** **N/A**
- **Treatment Care Plan** **Date of TCP** _____ **Yes** **No** **N/A**
- **Members Individual Education Plan** **Date of IEP** _____ **Yes** **No** **N/A**
- **OTHER DOCUMENTS ATTACHED** _____

_____

START DATE

****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 information included on this application is accurate.** ☐Yes ☐No

LIST DME CPT/HCPC: ***MAKE A COPY OF THIS PAGE FOR MULTIPLE CPT/HCPC CODES AND SUBMIT A PAGE PER***

CPT/HCPC-Quantity Ordered **Frequency of Use**

ICD DX Code(s) **Symptoms:**

Date of Anticipated Equipment Replacement

DME Vendor Cost Quote $
ATTACH Cost Invoice/Calculation

Clinical Indications for Items Requested—Mark all Applicable

☐***Medical Equipment***

☐***General Medical Equipment*** ☐***Other Medical Equipment*:**_____

☐**Enteral Nutrition**, If Yes-Enteral Feedings Product_____ Enteral Feedings Frequency_____

PLEASE CIRCLE ALL APPLICABLE CRITERIA BELOW FOR ENTERAL NUTRITION:

a) Permanent Impairment > 90 days from onset
b) Caloric Intake > 50% Daily
c) Impaired digestion, malabsorption or nutritional risk as indicated in anthropometric measures
d) Weight loss for adults showing: Involuntary or acute weight loss greater than or equal to 10% of usual body weight during a 3-6 month period or BMI below 18.5 kg/m2.
e) Weight loss for neonates, infants and children showing: Very low birth weight(LBW)even in the absence of gastrointestinal, pulmonary or cardiac disorders. Lack of weight gain or weight gain less than 2 standard deviations below the age appropriate mean in a 1 month period for children under 6 months or in a 2 month period for children 6-12 months. No weight gain or abnormally slow rate of gain for 3 months for children older than 1 year or documented weight loss does not reverse promptly with instruction in appropriate diet for age. Weight for height less than the 10th percentile.
f) Abnormal laboratory test pertinent to the diagnosis
g) Anatomic structure of the gastrointestinal tract that impairs digestion and absorption
h) Diagnosis of inborn errors or metabolism that require food products modified low in protein
i) Failure to Thrive(FTT) diagnosis that increases caloric need while impairing caloric intake and/or retention
j) Increased metabolic and/or caloric needs due to excessive burns, infection, trauma, prolonged fever, hyperthyroidism or illnesses that impair caloric intake and/or retention
k) Neurological disorders that impair chewing or swallowing
l) Prolonged nutrient losses due to malabsorption syndromes or short bowel syndrome, diabetes, celiac disease, chronic pancreatitis, renal dialysis, draining abscess or wounds
m) Treatments with anti-nutrient or catabolic properties

☐**Feeding Tube** ☐**IV Infusion Therapy**

☐**Mobility and Bathroom Safety Aids** ☐**Bathroom Safety Aids** ☐**LIST Other Mobility Aids**: _____

☐**Wheelchair:** *Manual* *Power* **(Be sure to Complete Page 3)**

☐***Medical Supplies*** ☐**Ostomy Supplies**

☐**Incontinence Supplies,** ***CIRCLE reason below:***

a) Patient has a congenital urinary tract abnormality causing incontinence
b) Patient has a neuromuscular defect causing incontinence
c) Patient has a developmental delay with urogenital sequalae
d) Other clinical evidence to support incontinence or inability to toilet train

☐***Respiratory Equipment*** ☐**BiPAP** ☐**CPAP** ☐**Nebulizer** ☐**Respiratory Equip-Ventilator**

☐**Oxygen(02)**

- Oxygen Liters or % of O2 Administered: _____ Oxygen Saturation:_____

☐**Respiratory Equip-Breathing Treatment**

- Breathing Treatment-Medication Administered_____ Breathing Treatment-Frequency_____

☐**Infant Apnea Monitors**

a) Birth Weight_____ Gestational Age(in weeks)_____
b) Sibling of SIDS ☐Yes ☐No
c) Infant with Narcotic Addict Mother ☐Yes ☐No
d) Infant with High-Risk Cardiac Disease ☐Yes ☐No
e) Infant with Tracheostomy ☐Yes ☐No
f) Prematurity ☐Yes ☐No
g) Parent/Guardian Certification (Attached ☐Yes ☐No)
h) Apnea Delay Rate(in seconds)_____
i) Apparent Life Threatening Event(ALTE) ☐Yes ☐No If Yes, complete below and attach all relevant ALTE documentation. Date of ALTE_____
Number of ALTE Episodes_____ ALTE Hospital Name_____
ALTE Hospital Admission Date _____ Discharge Date _____Follow-up appointment date: _____

☐**Other:** _____

ANSWER ALL QUESTIONS FOR A WHEELCHAIR REQUEST

Is there a current placement? ☐**Yes** ☐**No** **Date of Environmental Assessment** _____

If Yes, Type of Equipment: _____

Other Equipment Utilized Effectively: _____

How far can the person ambulate unassisted? ☐**>150 feet** ☐**0-50 feet** ☐**51-100 Feet** ☐**101-150 feet**

☐**Member is expected to grow in height** ☐**Member may increase in weight/width up to 5 inches**

☐**Member requires special developmental capability** ☐**Member weighs less than 125 pounds**

☐**Member may require a seat-to-back angle range of adjustment in excess of 12 degrees**

Is there a current placement	Yes	No
How far can the person ambulate unassisted?	>150 feet 0-50 feet	101-150 feet 51-100 Feet
Is this equipment modifiable to meet the member's future needs?	Yes	No
An environmental and functional assessment has been completed to determine that the equipment recommended based on the Physician's order is the most appropriate and cost effective to meet the member's basic health care needs?	Yes	No
Is wheelchair warranty in place for at least one year?	Yes	No
Can repairs be safely made to the current equipment?	Yes	No
If answer to questions 3-6 above is NO, please provider explanation here		
How was it determined that the wheelchair selected can be utilized effectively in the member's current environment?	Home/Site Visit Member of Caregiver Report	Equipment Utilized Effectively-Other Other:
Length of time member will use wheelchair daily	<2 hrs per day 2-8 Hrs per day	9-12 Hrs per day >12 hrs per day
The member will use the wheelchair primarily/routinely	Both inside and outside of the home Indoors on smooth hard surfaces	Outside on rough, unpaved, uneven surface Outside on smooth paved surfaces
The Member will encounter obstacles	<=.75 inches <.75 inches-<=1.5 inches	>1.5 inches-<=2.5 inches >2.5 inches
The Member has a documented medical need for a feature not routinely available on a lower level Power Wheelchair(PWC)	Yes	No
If Yes, Describe the required feature and the environment in which the PWC will be used and the routine performance of ADLS		
The Members requires a drive control interface other than hand or chin operated standard proportional joystick	Yes	No
If Yes, Control-Interface Explanation		
The member has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair and/or the member uses a ventilator that is mounted on the wheelchair	Yes	No
If Yes, Power tilt and recline seating explanation plus describe the ADLs that will be possible with the additional feature that would not be possible with the additional feature:		