



# WVCHIP PRIOR AUTHORIZATION FORM

**FAX 1.844-633-8431 PODIATRY**

Today's Date \_\_\_\_\_

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 ATTREZO  
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)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Contact Information</b>	<b>Phone</b>	<b>Fax:</b>

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

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>
<b>Address, City, State, Zip</b>	

Member WVCHIP Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Member Address, City, State, ZIP \_\_\_\_\_

Procedure Type: **PODIATRY**

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  OP Hospital  Surgical Center

### List ALL Relevant ICD Diagnosis Code(s):

Primary DX: \_\_\_\_\_ Symptoms: \_\_\_\_\_  
\*\*You may attach H&P or other relevant clinical documentation—if so, please write see attached\*\*  
Other DX: \_\_\_\_\_

**CPT/Service Code(s) Requested:** \_\_\_\_\_ **START DATE** \_\_\_\_\_

\_\_\_\_\_ Are the physician orders for each code attached? \_\_\_ Yes \_\_\_ No  
If No, please list why: \_\_\_\_\_

I certify that this patient meets the program eligibility criteria and that this equipment is a part 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

Certification Date: \_\_\_\_\_

Certifying Practitioner: \_\_\_\_\_

Certifying Practitioner ID: \_\_\_\_\_

Certifying Practitioner Phone: \_\_\_\_\_

## MEDICAL EVALUATION

Does patient have impaired endurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient have impaired mobility? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient have restricted activity? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient have skin breakdown? (If yes, describe site, size, depth, and drainage below) <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient require assistance with ADLs? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	
Does patient/caregiver demonstrate willingness and ability to use equipment? <input type="checkbox"/> YES <input type="checkbox"/> NO Medical Justification	

Length of Time Needed:

<input type="checkbox"/> 1-2 weeks	<input type="checkbox"/> 6-8 weeks
<input type="checkbox"/> 3-4 weeks	<input type="checkbox"/> Ongoing
<input type="checkbox"/> 5-6 weeks	

List Dollar Amount:

## ADDITIONAL ANNOTATIONS

Quantity Ordered: 1 2 3 4 5 6 7 8 9 10

<b>Frequency of Use:</b> <input type="checkbox"/> As Needed <input type="checkbox"/> Continuous <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<b>Functional Level:</b> <input type="checkbox"/> 0 <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV
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