WVCHIP PRIOR AUTHORIZATION FORM

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

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** _____

Member Address, City, State, ZIP _____

Procedure Type: Pulmonary Rehab **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** ☐ **Clinic** ☐ **OP Hospital**

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

Other DX:

CIRCLE Service Code(s) Requested:

START DATE_____

_____**GO237** _____**G0238** _____**G0239**

Are the physician orders for each code attached? ___Yes ___No If No, please list why:

_____

MARK ALL APPLICABLE AND SUPPLY JUSTIFICATION OF MEDICAL NECESSITY FOR INITIAL ADMISSION:

	Chronic Pulmonary Disease
	Member does not have a recent history of smoking or has quit smoking for at least 3 months
	Other Condition that affects Pulmonary Function
	Reduction of exercise tolerance restricting the ability to perform activities of daily living.

JUSTIFICATION OF MEDICAL NECESSITY

TREATMENT PLAN-PREVIOUS COURSE OF TREATMENT

CURRENT PLAN OF CARE

FREQUENCY # OF SESSIONS/WEEK_____**Start Date**_____ **End Date**_____

PLANNED INTERVENTION/TREATMENTS-EXERCISE TRAINING DURATION ☐20 Minutes ☐40 Minutes ☐60 Minutes ☐Other

DESCRIPTION OF OTHER:

PLANNED INTERVENTIONS/TREATMENTS EXERCISE/TRAINING SESSION (Check all applicable)

☐ Exercise Program ☐ Team Assessment ☐ Member Follow-Up ☐ Psychosocial Intervention

MEMBER TRAINING/EDUCATION (Check all applicable)

☐ Breathing Retraining ☐ Bronchial Hygiene ☐ Medication Education ☐ Nutrition Education

PSYCHOSOCIAL INTERVENTION (Check all Applicable)

☐ Anxiety Evaluation & Management ☐ Assessment/Development of emotional support systems

☐ Dependency Issues/Evaluation Management ☐ Other Psychosocial

PLANNED INTERVENTIONS/TREATMENTS EXERCISE/TRAINING SESSION EXPLANATION

EXPECTED OUTCOMES/GOALS (Check all applicable)

☐ Educate Members/Significant Others about the disease, treatment options and strategies

☐ Encourage Members to be actively involved in healthcare ☐ Maintain Health Behaviors

☐ Reduce/Control breathing difficulties and symptoms ☐ Restore the member to the highest possible level of independent function

ADDITIONAL ANNOTATION: