WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8428 LAB/IMAGING/RADIOLOGY**

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON HTTPS://PROVIDERPORTAL.APSHEALTHCARE.COM

C3 Requesting/Submitting Organization _____ Please list exactly as registered on C3

Address, City, State, Zip _____

Registered C3 Requesting/Submitting Organization NPI _____ Please list exactly as registered on C3

Person Submitting Request _____ **Phone** _____ **Fax** _____ **Email**_____

Referring/Ordering Provider

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

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 WV Medicaid)

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

Member Medicaid Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Member Address, City, State, ZIP _____

Procedure Type: ☐**LAB** ☐**IMAGING** ☐**RADIOLOGY**

Authorization Type: ☐**Prior Authorization**

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

☐**Denied by Member's Primary Payer** ☐**Retrospective Medicaid Eligibility**

List Other Retro Reason:

For Members under age 21, is this request an EPSDT referral? ☐**Yes** ☐**NO** ****If yes, please submit the most current EPSDT form on file****

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

Place of Service: ☐ **Office** ☐ **Home** ☐ **Mobile Unit** ☐ **Urgent Care Facility** ☐ **Inpatient Hospital** ☐ **Outpatient Hospital** ☐ **Emergency Room**

☐ **Ambulatory Surgical Center** ☐ **Birthing Center** ☐**Military Treatment Facility** ☐ **Independent Clinic** ☐ **Independent Lab**

List ALL Relevant ICD Diagnosis Code(s):

Primary DX: _____ Symptoms: _____

Other: _____

CPT/Service Code(s) Requested:

START DATE_____

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

_____

Justification of Medical Necessity:

You may attach H&P and/or other relevant clinical documentation (i.e. previous diagnostic study results)—if so, please write see attached

Current Course of Treatment

Conservative Treatment History *To include Activity Modifications + NSAID trial—list duration & outcome for both or why not tried.*

You may attach treatment plan—if so, please write see attached

PLEASE INDICATE/INCORPORATE ALL ASSOCIATED MEDICATIONS, TREATMENTS, THERAPIES, PREVIOUS DIAGNOSTIC STUDIES, ETC. (TO INCLUDE THE RELATION, DURATION, OUTCOMES, ACTIVITY MODIFICATIONS):

Is this request pertaining to a Cancer Diagnosis? ☐ YES ☐ NO

If Yes, Date of Diagnosis: _____

If Yes, Family History of Cancer: ☐ **YES** ☐ **NO** **Personal History of Cancer:** ☐ **YES** ☐ **NO**

If Yes, Family Member with a known BRCA1/BRCA2 Mutation: ☐ **YES** ☐ **NO**

If Yes, Findings:

If Yes, Diagnosis Ruled Out:

If Yes, this service request is related to:

☐ **Disease Progression** ☐ **Metastasis** ☐ **New Diagnosis** ☐ **New Symptoms**

☐ **Recurrence** ☐ **Restaging** ☐ **Treatment Planning**

If Yes, Current Course of Treatment: