REGISTRATION MUST BE COMPLETED TO FAX DURABLE MEDICAL EQUIPMENT FORMS
WVMI DURABLE MEDICAL EQUIPMENT FAX# 1-877-762-4338
DETERMINATIONS ARE AVAILABLE ON HTTPS://PROVIDERPORTAL.APSHEALTHCARE.COM

WV MEDICAID PRIOR AUTHORIZATION REQUEST FOR DME SERVICES

Today's Date_____

Requesting/Submitting Organization_____

Requesting/Submitting Organization NPI_____

Submitting Organization Address_____

Submitting City, State, Zip_____

Person Submitting Request_____

Phone Number of Person Submitting_____

Member Name_____

1 **MANDATORY FOR ALL ACCEPTABLE SUBMISSION PAGES:**

Required	Optional	Included	Not included
Page 1			
Page 2			
Page 3			
Page 4	*REQUIRED	FOR EACH	CODE
Page 5	*REQUIRED	FOR EACH	CODE
Page 6			
Page 7			
Page 8			
Page 9			
Page 10			
Page 11			

We encourage providers to register with APS Healthcare to submit prior authorization request electronically.

Please indicate all documentation in support of/or to give additional support information for prior authorization approval in space provided below.

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Referring Provider

Name	
Address One	
Address Two	
City, State, Zip	
Office Contact Name	
Contact Phone Number	

Servicing Provider

Name	
NPI number	
Address One	
Address Two	
City, State, Zip	
Office Contact Name	
Contact Phone Number	

Member Medicaid Number_____ **Member SSN**_____

First Name_____ **Middle**_____ **Last Name**_____

DOB_____ **Parent/Guardian (if Minor)**_____

Member Address_____

Member Address One_____

City, State, ZIP_____

WV County of Residence_____

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Authorization Start Date_____ Date of Referral_____

Authorization Type: ☐Prior Authorization

☐ Retrospective Request (if applicable)

Reason for Retrospective Request

☐After hours/weekend admission

☐Failure to Request PA

☐Denied by Member's Primary Payer

☐Other

Explanation for Other:

☐Retrospective Medicaid Eligibility

For Members under age 21, is this request an EPSDT referral? ☐Yes ☐NO

****If yes, please submit the most current EPSDT form on file****

A SERVICE/CPT CODE IS REQUIRED FOR REVIEW. A DME CODE LISTING CAN BE FOUND @ www.apshealthcare.com/wv. THE PROVIDER WILL NEED TO FIND EACH CODE AND PRINT THAT PAGE ONLY. CIRCLE THE CODES NEEDED AND FAX WITH PAGES 01-11

Please note: If a non-specific or miscellaneous supply code is selected and there is another more appropriate code that can be used, the authorization request will be closed.

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Request Type ☐New ☐Repair ☐Replacement

Length of Time Needed ☐ Days ☐Months ☐Ongoing ☐Permanent ☐Weeks

☐Years

Service Start Date:_____ **CPT/HCPC-Quantity Ordered**

Number of

Frequency of Use

Date of Anticipated Equipment Replacement

DME Vendor Cost Quote

Cost Message

4

Cost Invoice and other Documentation ☐Attached ☐Fax

Clinical Indications for Items Requested

If Member is under age 21, does member have an Individual Education Plan(IEP) that includes these services? ☐Yes ☐No

If yes, please attach a copy in the annotation section.

Are Physician's Order(s) Attached? ☐Yes ☐No

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If no, please provider explanation in the space provided below

****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 signature in Annotation Section.

Date of Order_____

5 **Diagnosis Code(s):_____**

Date of Onset:_____

Symptoms:_____

_____

_____

_____

_____

_____

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☐**Medical Equipment**

☐**General Medical Equipment**

☐**Enteral Nutrition**

Feeding Tube ☐**Yes** ☐**No**

If Yes-Enteral Feedings Name_____

Enteral Feedings Frequency_____

Criteria listed below-Place check mark in space provided

	Permanent Impairment > 90 days from onset
	Caloric Intake > 50% Daily
	Impaired digestion, malabsorption or nutritional risk as indicated in anthropometric measures
	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.
	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.
	Abnormal laboratory test pertinent to the diagnosis
	Anatomic structure of the gastrointestinal tract that impairs digestion and absorption
	Diagnosis of inborn errors or metabolism that require food products modified low in protein
	Failure to Thrive(FTT) diagnosis that increases caloric need while impairing caloric intake and/or retention
	Increased metabolic and/or caloric needs due to excessive burns, infection, trauma, prolonged fever, hyperthyroidism or illnesses that impair caloric intake and/or retention
	Neurological disorders that impair chewing or swallowing
	Prolonged nutrient losses due to malabsorption syndromes or short bowel syndrome, diabetes, celiac disease, chronic pancreatitis, renal dialysis, draining abscess or wounds
	Treatments with anti-nutrient or catabolic properties

☐**IV Infusion Therapy**

☐**Other Medical Equipment**

Please provide details if Other Medical Equipment is selected in the space below

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☐**Mobility and Bathroom Safety Aids**

☐**Bathroom Safety Aids**

☐**Other Mobility Aids- Please answer questions below**

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

☐**Wheelchair** ☐**Manual** ☐**Power**

Is there a current placement? ☐**Yes** ☐**No**

If Yes, Type of Equipment

Other Equipment Utilized Effectively

If Power Wheelchair, please provide reason requested below

Pediatric Wheelchair Questions Only

☐**Member is expected to grow in height**

☐**Member may increase in weight/width up to 5 inches**

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

☐**Member requires special developmental capability**

☐**Member weighs less than 125 pounds**

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Date of Environmental Assessment_____

Please answer all questions below if for a Wheelchair Prior Authorization Request

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**	**Other** **Equipment Utilized Effectively-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 surfaces** **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		

Describe the ADLs that will be possible with the additional feature that would not be possible with the additional feature:

☐**Respiratory Equipment**

☐**BiPAP** ☐**CPAP** ☐**Infant Apnea Monitors**

☐**Nebulizer** ☐**Oxygen(02)**

Respiratory Equipment-Ventilator ☐**Yes** ☐**No**

Respiratory Equipment-Breathing Treatment ☐**Yes** ☐**No**

Breathing Treatment-Medication Administered_____

BreathingTreatment-Frequency_____

Oxygen Liters or % of O2 Administered_____

Oxygen Saturation_____

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FOR INFANT APNEA MONITOR ONLY

Birth Weight_____ **Gestational Age(in weeks)_____**

Sibling of SIDS ☐Yes ☐No

Infant with Narcotic Addict Mother ☐Yes ☐No

Infant with High-Risk Cardiac Disease ☐Yes ☐No

Infant with Tracheostomy ☐Yes ☐No

Prematurity ☐Yes ☐No

Parent/Guardian Certification ☐Attach ☐Fax

Apnea Delay Rate(in seconds)_____

Apparent Life Threatening Event(ALTE) ☐Yes ☐No

If Yes:

Date of ALTE_____

Number of ALTE Episodes_____

10 **ALTE Hospital Name_____**

ALTE Hospital Admission Date_____

ALTE Hospital Discharge Date_____

ALTE Documentation

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☐**Medical Supplies**

☐**Incontinence Supplies**

☐ **Patient has a congenital urinary tract abnormality causing incontinence**

☐**Patient has a developmental delay with urogenital sequalae**

☐**Patient has a neuromuscular defect causing incontinence**

☐**Other clinical evidence to support incontinence or inability to toilet train**

☐**Ostomy Supplies**

☐**Other-Please explain**

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Follow-up appointment date: _____

Any additional notes please indicate in the space below.

If a Non-Specific or Miscellaneous code is chosen, please provide a description of the service/services in the box below. Please note: If a nonspecific or miscellaneous supply code is selected and there is already a code that can be used, the authorization request will be closed.

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