PRIOR AUTHORIZATION FOR SERVICES

What is prior authorization and what services need prior authorization?

Prior authorization is a review process that helps WVCHIP decide if services are medically necessary and covered by WVCHIP. It also helps determine what WVCHIP and members must pay for medical services. WVCHIP requires prior authorization for ALL services outside the state of West Virginia, except for:

- prior authorization for office visits to primary care doctors (family & general medicine doctors, internists, and pediatricians) in counties bordering WV, or
- for emergency services, or
- services from providers who have agreed to accept the same payment as providers in state.

Your Summary Plan Description (SPD) has more information.

What happens when I don't get prior authorization when I need to?

If you don't get prior authorization for out-of-state services you may have to pay for 100% of what the provider bills. See the Summary Plan Description (SPD) at www.chip.wv.gov.

What do I have to pay when I do get prior authorization for services?

Prior authorization means services will be paid for by WVCHIP. You will only have to pay the copayment, if there is one.

When is prior authorization given?

Prior authorization will be given for out-of-state services that are NOT available in West Virginia reasonably close to your home or if the member needs services that are not available in the state. Contact HealthSmart for criteria for authorization for out of state services. If the member can get care by an equivalent specialist in West Virginia in a reasonable distance, prior authorization will NOT be given. Prior authorization is NOT given because you prefer an out-of-state provider or think the local provider is not as good. You may get care from the provider you choose but you will have to pay much more.

How do I get out-of-state services prior approved?

Complete the form on the next page and either mail or fax it to HealthSmart Care Management Solutions. One form must be completed for each provider (doctor, clinic, hospital, etc.) you want to see.

Mail this form to:	**HealthSmart Care Management Solutions** **PO Box 1921** **Charleston, WV 25327**	**OR**	**Fax both sides of the form to:** **HealthSmart at 1-806-473-2770**

How long does a typical prior authorization request take?

A typical request will take about ten days to complete. If you don't give all the information needed it may take as long as four to six weeks. You will get written notice about this request. If your provider thinks it is urgent, a faster process may be used.

Providing Incomplete information on this form may delay this request

REQUEST FOR PRIOR AUTHORIZATION OF SERVICES:

Employee/Guardian Name:

_____

Street Address:

_____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Member ID#: ___ Effective Date of Coverage: _____

(For WVCHIP this is the child's ID)

Patient Name: _____ Relationship to Employee/Guardian: _____

Referring Physician: _____ Telephone: _____

Address/City/State/Zip: _____

Services Requested for Authorization and Reason for Request (please include a description of the proposed services and the specific reason(s) for care being requested, including past treatment done if applicable):

_____

_____

_____

_____

Provider being requested for authorization: _____

Specialty:_____ Telephone: _____

Address/City/State/Zip: _____

Facility being requested for authorization: _____

Address/City/State/Zip: _____

Date of Appointment or Procedure (if scheduled): _____

Please complete this section to allow HealthSmart to obtain information for processing of request and/or claims.

Authorization to Release Information:

I authorize _____

(Provider's Name)

_____

(Provider's Address/City/State/Zip)

to release to HealthSmart all information relating to past, present, and future health care examinations, conditions, and treatments for: _____

_____

(Brief Description of Medical Condition)

By signing below, I am requesting prior authorization for the provider, facility, and services listed on the front of this form and I am authorizing release of information for the provider noted above. I have read and understand the attached information regarding the prior authorization process.

Patient's Signature:** _____ **Date:** _____

**** If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of legal information.**

Employee/Guardian Signature: _____ **Date:** _____

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