Monitoring and Treatment 9.11 WTC Health Program

Standard
Prior Authorization Level 3 (PA-3) Request Form

Submission Instructions: Please complete this form and other sections as appropriate and send it to the World Trade Center Health Program by posting it to the secure SFTP server and then sending an email to WTCMedCode@csc.com indicating the secure server posting of this request. Incomplete forms will be sent back for more information. Not to be used for dental or transplant requests. DO NOT FILL OUT NIOSH DECISION OR NIOSH DECISION RATIONALE.

General and Member Information

Request Date

Member Type

◯ Responder ◯ Survivor

Member Name

Choose a CCE/NPN

Member Date of Birth

Member 911#

Relevant Certified Condition

ICD Code

Relevant Certified Condition

ICD Code

Relevant Certified Condition

ICD Code

CCE/NPN Requester Information

Requester Name

Requester Credentials

Requester E-mail

Requester Phone

Clinical Director Name (if not requester)

Clinical Director Concurrence Signature

Standard Authorization Request (Non Dental)

Procedure/Service

CPT Code

NIOSH Decision

NIOSH Decision Rationale

Procedure/Service

CPT Code

NIOSH Decision

NIOSH Decision Rationale

Procedure/Service

CPT Code

NIOSH Decision

NIOSH Decision Rationale

Procedure/Service

CPT Code

NIOSH Decision

NIOSH Decision Rationale

Procedure/Service

CPT Code

NIOSH Decision

NIOSH Decision Rationale

Clinical Summary Please describe the type of procedure(s)/service(s) requested above. Please provide medical necessity rationale describing how they relate(s) to the treatment or management of the certified WTC-related condition or medically associated condition. Treatment must be non-experimental and non-investigational . Document any other designated criteria noted in the WTCHP Codebook guidelines for the procedure(s)/service(s), WTCHP Policy and Procedures Manual or WTCHP Codebook guidelines.

TO BE FILLED OUT BY A NIOSH

Name

Credentials

NIOSH Decision

Signature

NIOSH Decision Comments