Public Employees
Insurance Agency

REQUEST FOR PRIOR APPROVAL OF SERVICES

The WV PEIA Preferred Provider Benefit Plan (PPB) requires prior approval for all services from:

- out-of-state, out-of-network (OOS, OON) providers, and
- in-network providers located beyond the counties bordering WV (OOS, IN) **if** the member does not live in the state where the in-network services are provided.

PEIA PPB Plan members must use PPO network providers to receive the higher in-network level of benefits. The PPO network consists of West Virginia providers who accept PEIA's reimbursements and out-of-state providers who contract with Aetna Signature Administrators (ASA) PPO. Also, Wells Fargo TPA contracts directly with some providers in counties that border West Virginia. These providers are a part of the PPO network.

NOTE: A member's out-of-pocket costs can be significant (2 times the deductible PLUS 40% co-insurance PLUS any charges over PEIA's allowed amount) when prior approval is required but not obtained.

To apply for prior approval, **read and complete both sides** of this form, then mail it to ActiveHealth at the address on the back or fax both sides to 1-866-938-0353. A separate form must be completed for each provider (doctor, clinic, hospital, etc.) from whom you seek services.

Policyholder Name:____

Street Address: ____

City:____ State:_______ Zip: _______________________

Home Telephone: (________)_______________________ Work Telephone: (_________)______________________

Member ID #:_____________________________________ Effective Date of Coverage: _______________________

Patient Name: ______________________________ Relationship to Policyholder: _____________________

Patient Date of Birth (mm/dd/yyyy): __________________________________

Referring Physician: __________________________ Phone Number: (_________)______________________

Address/City/State/Zip: ____

Provider Being Requested for Approval: ____

Specialty: ______________________________Phone Number: (_________)______________________

Address/City/State/Zip: ____

Date of Appointment or Procedure (if scheduled): ____

Reason for request (please provide a description of the proposed service and the specific reason(s) for care being requested out-of-state or out-of-network, including treatment done locally; attach additional sheets, if needed)

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All information must be provided on both sides of this form to process this request.

IMPORTANT INFORMATION ABOUT YOUR REQUEST FOR PRIOR APPROVAL

Prior approval will only be granted for medical care that is not available within WV within a reasonable travel time, or for a medical condition that requires specialized services not readily available within the state. If care by an equivalent specialist is available within a reasonable geographic range, approval for the higher benefit for out-of-network services will not be granted.

PEIA PPB Plan members who live in West Virginia or a bordering county may receive care from any WV provider who accepts PEIA, or any network provider located in a bordering county without receiving prior approval. For services of network providers, PEIA will pay 80% of the contracted payment rate; the patient is responsible for the deductible and 20% coinsurance. For services of non-network providers without prior approval, PEIA will pay 60% of reasonable and customary (R&C) charges; the patient will be responsible for a doubled deductible, the 40% coinsurance plus any amount that exceeds R&C.

You **will not** be granted benefits at the higher level based solely on your personal preference for an out-of-network/out-of-state provider or due to your perception that the local provider is not of the same quality as the physician you are requesting. You may access care from the provider of your choice, however if it is for these reasons, it will most likely not be allowed at the higher benefit level.

If proposed care is to be provided by an Out-of-State, Out-of-Network provider, then this section must also be completed to allow ActiveHealth to obtain information for processing of request and/or claims.

Authorization to Release Information

I authorize____
(Non-Network Provider's Name)

____
(Address/City/State/Zip)

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

____
(Brief Description of Medical Condition)

____

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By signing below, I am requesting prior approval for the provider and services listed on the front of this form and if applicable, I am authorizing release of information for the non-network provider noted above.

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 medical information.

Employee/Guardian Signature: ________________________________ **Date:** _____________________

Mail this form to: **ActiveHealth**
PO Box 221138
Chantilly, VA 20153-1138

OR

Fax both sides of the form to:
ActiveHealth at 1-866-938-0353

Note; A typical prior approval request will take about ten days to complete. If complete medical information is not provided and additional research is necessary, the evaluation of your request by ActiveHealth may take four to six weeks. You will receive written notification regarding your request. If your provider considers the situation to be medically urgent, an expedited process may be implemented at ActiveHealth's discretion.

All information must be provided on both sides of this form to process this request.