# Assertive Community Treatment (ACT) Prior Authorization Request Form
## Acentra Health

***SCDHHS now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) to include their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp***

**Submit fax request for Prior Authorization to: 1-855-300-0082**
**Requests may be submitted up to 30 days prior to treatment**

| | | | | | |
|---|---|---|---|---|---|
| **1.** ☐ **Initial** | ☐ **Recertification** | ☐ **Change** | ☐ **Cancel** | **Recert: Enter previous PA#. Change or Cancel: Enter PA# to be changed or canceled.** | **PA #** |
| 2. **Date of Request (mm/dd/yyyy)** / / | 3. **Review Type (check one if applicable)** ☐ Prior Authorization ☐ Retrospective Review (Date notified of eligibility / / ) | | | | |
| 4. **Member Medicaid ID Number** (10 digit Number): | 5. **Member Last Name**: | 6. **Member First Name:** | 7. **Date of Birth** (mm/dd/yyyy): / / | 8. **Gender:** ☐ Male ☐ Female | |
| *9.* **a. NPI/Requesting Service Provider Name & ID Number:** **b. 9 digit Zip Code (Mandatory)** | 10. **Treatment Setting** ☐ Outpatient/Community | | 11. **Primary Diagnosis Code: (enter up to 5)** 1. 2. 3. 4. 5. | | |
| 12. **a. NPI/Rendering Provider Name and ID Number:** **b. 9 digit Zip Code** ***(Mandatory)*** | 13. **Prior Auth Service Type:** ☐ Assertive Community Treatment (ACT) | | | | |
| 14. **Clinical Information (Thorough Clinical Assessment, including symptoms, stressor or other pertinent information, Plan of Care/Goals) attach notes as needed.** | | | | | |

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| Number | 15. HCPCS/ CPT Code | 16. Code Description | 17. Modifiers (if applicable) | 18. Units Requested (If Applicable) | 19. Frequency | 20. Dates of Service | |
|---|---|---|---|---|---|---|---|
| | | | | | | From (mm/dd/yyyy) | Thru (mm/dd/yyyy) |
| 1. | | | | | | / / | / / |
| 2. | | | | | | / / | / / |
| | | | | | | | |
| 21. Contact Name: | | | | | | | |
| 22. Contact Telephone Number: | | | | | | | |
| 23. Contact Fax Number: | | | | | | | |

## Additional Information

**15. Significant Functional Impairment – please check those that apply**

☐Difficulty consistently performing the range of routine tasks required for basic adult functioning in the community
☐Difficulty maintaining consistent employment at a self-sustaining level or difficulty carrying out the head-of-household responsibilities
☐Difficulty maintaining a safe living situation

**16. High Service Needs – please check those that apply**

☐High use of acute psychiatric hospitalizations (two or more in past 12 months)
☐Intractable severe psychiatric symptoms
☐Coexisting mental health and substance use disorders (e.g., affective, psychotic, suicidal, etc)
☐High risk or recent history of criminal justice involvement
☐Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness
☐Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if mor e intensive services are not available.
☐Difficulty effectively using traditional office-based outpatient services

**17. CONTINUED STAY REVIEW – Complete only if you are requesting a Continued Stay review for a current/active Prior Authorization. Please check those that apply.**

☐Has achieved current treatment plan goals and additional goals are indicated
☐Making satisfactory progress toward meeting goals, and there is documentation that supports continuation of ACT
☐Making moderate progress, but the specific intervention in the treatment plan need to be modified so that greater gains are possible
☐Fails to make progress or demonstrates regression in meeting goals through the intervention outlined
☐Regression is highly anticipated if patient discharged: documented history of regression in absence of ACT or there is an epidemiologically sound expectation that symptoms will persist, and treatment interventions are needed to sustain functional gains.

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### INSTRUCTIONS FOR ASSERTIVE CARE TREATMENT (ACT) ELECTRONIC FAX FORM

**http://scdhhs.kepro.com**

This FAX submission form is required for faxed ACT Initial Certification, Recertification/Continued Stay reviews, and Retrospective Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on Acentra Health forms can be entered.

If Acentra Health determines that your request meets appropriate coverage criteria guidelines, final approval is contingent upon passing remaining Member and Provider eligibility/enrollment edits. The Prior Authorization number provided by Acentra Health will be provided to you via fax back process and will be available to providers registered on the web-based program Atrezzo (https://portal.kepro.com). **This excludes weekends and holidays.**

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject or administrative denial would also be an initial request.
   - **Recertification/Continued Stay Review:** A request for continued services beyond the expiration of the previous Prior Authorization.
   - **Change**: A change to a previously approved request. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may **not** submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one Prior Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Member number.
2. **Date of Request:** The date you are submitting the Prior Authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the service being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 10 digits
5. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
6. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.
7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Gender:** Please place a √ or **X** to indicate the sex of the member.
9. **a. NPI Requesting /Service Provider Name and ID Number:** Enter the requesting/service provider name and National Provider Identifier (NPI).

**b. 9 digit Zip Code (Mandatory):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.

10. **Treatment Setting:** Place a √ or **X** to indicate the place of service. Ex: Mental Health Counseling: Mark "Outpatient".
11. **Primary Diagnosis Code /Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).
12. **a. NPI Rendering Provider Name and ID Number:** Enter the rendering provider name and National Provider Identifier (NPI) for the provider performing the service.

    **b. 9 digit Zip Code (Mandatory):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted,
13. **Prior AUTH Service Type:** Place a √ or **X** to indicate the category of service you are requesting
14. **Clinical Information :**

    - This field must include a summary of the clinical assessment and treatment plan for the member. Attach copies of the full assessment, treatment plan, goals, and objectives.

15. **HCPCS/CPT:** Provide the appropriate code for ACT services
16. **Code Description:** Provide the HCPCS/CPT procedure code description.
17. **Modifiers (if applicable):** Enter modifiers as applicable. There are two possible modifiers for ACT
18. **Units Requested**: Based on physician's orders, plan of care, or MCMN provide the number of services/visits requested. Knowledge of InterQual/SCDHHS criteria will be extremely helpful. Place numbers only in the Units Requested block. **(If Applicable)**
19. **Frequency:** Enter Frequency usage of Service requested- (if Applicable – up to 6 months can be approved)
20. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
21. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
22. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
23. **Contact Fax Number:** Enter the fax number with the area code to receive the outcome determination.

***Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.**

**The purpose of Prior Authorization is to validate that the service being requested is medically necessary and meets SCDHHS criteria for reimbursement.**

**Prior Authorization is based on medical necessity and is not a guarantee of payment.**