***“KePRO/SCDHHS now require any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) to provide their 9 digit zip code. If you do not know your 9 digit zip codes then please visit:*** [***http://zip4.usps.com/zip4/welcome.jsp***](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 scheduled procedures/services, provided the Member is eligible.**

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| **1.**  **Initial** | | **Recertification** | | | **Change** | | **Cancel** | | **Recert: Enter previous PA#. Change or Cancel: Enter PA# to be changed or canceled.** | | | **PA #** |
| 1. **Date of request: (mm/dd/yyyy)**   /  / | | | | | 1. **Review Type: (Please check one if applicable)**   Prior Authorization  Retrospective Review (Date notified of eligibility   /  / | | | | | | | |
| 1. Member Medicaid ID Number (10 Digit number): | | | | | 1. **Member Last Name:** | | | | | | 1. **Member First Name:** | |
| 1. **Date of Birth: (mm/dd/yyyy)**     /  / | | | | | 1. **Sex:**   **Male**  **Female** | | | * 1. **NPI Submitting Provider Name:**   2. **Medicaid ID Number:**   **c. 9 digit Zip Code**       (***Mandatory*)** | | | | |
| * 1. NPI Facility Name:   2. 9 Digit Zip Code:       (mandatory) | | | | | | | | 1. **Treatment Setting /Service Type:**   **Inpatient** | | | 1. Surgical Admission:   **Yes**  **No** | |
| 1. **Admission Date: (mm/dd/yyyy)**     /  / | | | | 1. **Admission Status:**   **Elective**  Emergency | | | | 1. Primary Diagnosis Code/Description: | | | | |
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| 16. Service type:      Inpatient      Freestanding Inpatient Psychiatric under 21 or 65 and older | | | | | | | |  | | |  | |
| **17. Number of Days Requested:** | | | | | | | | 18. Attending Physician NPI: | | | | |
| 19. Procedure Code/Description (if applicable): | | | | | | | | 20. Procedure Scheduled Date: (mm/dd/yyyy)   /  / | | | | |

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# Additional Information

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| 1. Severity of Illness: |
| 1. **Intensity of Services:** |
| **23. Freestanding Inpatient Psychiatric Hospital Services for Children under 21 and 65 and older :**  **CON signed and dated by the physician and 2 members of the interdisciplinary team?  Yes  No**  **Date of CON:   /  /** |
| **24. Contact Name:**  **25. Contact Telephone Number:**  **26. Contact Fax Number:** |
| **27. Additional Comments (See instructions)** |

**INSTRUCTIONS FOR ELECTRONIC FAX FORM**

This FAX submission form is required for inpatient Prior Authorization Review, Admission, Concurrent Review and Retrospective Review. 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 required on **KePRO** forms can be entered. e.g. Surgical Justification form for Hysterectomy **(DHHS FORM 1729).**

If KePRO 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 (PA) number provided by KePRO will be sent to you through the normal letter notification process and will also be available to providers registered on the web-based program Atrezzo Connect (<http://scdhhs.kepro.com>). **This excludes weekends and holidays.**

1. **Request type:** Place a √ or **X** in the appropriate box.
   * **Initial:** Use for all newrequests. Resubmitting a request after receiving a reject would be an initial request also.
   * **Change**: A change to a previously approved request; the provider may change the notes fields. 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. If Retrospective, please review SCDHHS policy and procedure . 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. **Sex:** Please place a **√** or **X** to indicate the sex of the patient.
9. **a. NPI Submitting Provider Name:** Enter national ID number. Enter the requesting physician’s name

**b. Medicaid ID Number:**  Medicaid ID number

**c. 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.

1. **a. NPI Facility Name:** Enter the name and Medicaid Identification number and national provider identifier.

**b. 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.

1. **Treatment Setting:** Place a √ or **X** to indicate the place of service.
2. **Surgical Admission:** Indicate if this admission is surgical by placing a √ or **X** for yes or no in the appropriate box.
3. **Admission Date:** Indicate the planned admission date using the mm/dd/yyyy format.
4. **Admission Status:** Place a √ or **X** for Urgent/Elective admission. This refers to the clinical status of the patient that is being admitted. **(Mandatory Field)**
5. **Primary Diagnosis Code /Description:** Provide the **primary** **diagnosis code and description indicating** the reason for admission.
6. **Service type:** Place a √ or **X** to indicate the category of service you are requesting
7. **Number of days requested:** Based on your judgment provide the number of days requested for this admission diagnosis. Knowledge of InterQual /SCDHHS criteria will be extremely helpful.
8. **Attending Physician Medicaid ID Number NPI:** Provide the Attending Physician’s Medicaid ID number or national provider identifier. (If Known)
9. **Procedure Code /Description:** Provide the ICD-9 procedure code and description to indicate the reason for the patient’s admission. (If applicable)
10. **Procedure Scheduled Date:** If the procedure is scheduled on a different day from the planned admission date, indicate the date of the procedure (mm/dd/yyyy). (If applicable)
11. Severity of Illness (Clinical indicators of illness including abnormal findings): One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/SCDHHS criteria will be helpful to provide pertinent information. Provide the clinical information of chief complaint, history of present illness, pertinent past medical history and previous treatment to substantiate the need for hospitalization and level of service for the requested admission/procedure. This field should include pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities. Include supportive diagnostic outpatient procedures and abnormal finding on physical examination. This information also assists the reviewers in further assessing the patient’s condition. (Always include dates, types & results [with dimensions/% as appropriate]). Include TDO (Temporary Detention Order) date if applicable.
12. **Intensity of Services (Proposed /Actual monitoring and therapeutic services)\*:** This is another critical area of the form. Knowledge of the InterQual/SCDHHS criteria will be helpful to provide pertinent information. This field must include the treatment plan for the patient while in the facility. List the services, procedures, or treatments that will be provided to the patient while in the facility.
13. **Freestanding Inpatient Psychiatric Hospital services for children under 21** **ONLY:**

Please confirm CON signed and dated by the physician and 3 members of the team and provide date signed.

1. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
2. **Contact Phone Number:** Enter the phone number with area code of the contact name.
3. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial /reject.
4. **Additional Comments:** This area should be used for further information and other considerations and circumstances to justify your request for medical necessity or the length of stay. For example, if a patient has been treated several times as an outpatient and failed therapy or has not followed through on treatment, then information of this sort should be placed here. For psychiatric cases, list the DSM-IV if available.

\****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 does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the Member’s continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.***