Surgical Procedures Prior Authorization Request Form
South Carolina Department of Health and Human Services

Acentra Health, SCDHHS QIO now requires 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 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 10 days prior to schedule Surgical Procedures, provided Member is eligible.

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 Prepayment 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** ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Provider's Office	11. **Primary Diagnosis Code/ Description:** 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:** ☐ Surgical Procedure(s) ☐

14. **Severity of Illness (See instructions pertaining to each Prior Auth service type):**
15. **Intensity of Services (See instructions pertaining to each PRIOR AUTH service type):**
16. **Additional Comments (See instructions pertaining to each PRIOR AUTH service type):**

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Number	17. Procedure Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Dates of Service	
					From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.					/ /	/ /
2.					/ /	/ /
3.					/ /	/ /
4.					/ /	/ /
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8.					/ /	/ /
9.					/ /	/ /
10.					/ /	/ /
11.					/ /	/ /
12.					/ /	/ /
13.					/ /	/ /
14.					/ /	/ /
15.					/ /	/ /
16.					/ /	/ /
17.					/ /	/ /
18.					/ /	/ /
22. Contact Name:						
23. Contact Telephone Number:						
24. Contact Fax Number:						

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INSTRUCTIONS FOR FAX FORM

http://scdhhs.kepro.com

This FAX submission form is required for faxed Surgical Procedures or Organ Transplant Initial Certification, Recertification, and Retrospective Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiali ty 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 up on passing remaining Member and Provider eligibility/enrollment edits. The Prior Authorization (PA) number provided by Acentra Health via fax back process will also be available to providers registered on the web-based program Atre zzo 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 new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous Prior Authorization would be a recertification request.
   - **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 SCDHHS Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services 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. (Mandatory Field)
10. **Treatment Setting:** Place a √ or **X** to indicate the place of service. Outpatient Psych: Mark "Outpatient".
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 descriptions and ICD-9 codes.
12. **a. NPI Rendering Provider Name and ID Number:** Enter the servicing provider name and National Provider Identifier (NPI).

    b. 9-digit Zip Code (Mandatory): Providers must enter their 9 digit zip code. (Mandatory Field)
13. **PRIOR AUTH Service Type:** Place a √ or **X** to indicate the category of service you are requesting.
14. **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 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 (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions / % as appropriate]).
    - Service Type specific instructions:

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Surgical Procedures	Surgical Procedure being requested (See Appendix B). Reason for the surgery. Include any Pertinent Medical History. Full Vital Signs (Temperature, BP, P, RR, Pulse Oximetry on Room Air) Abnormal Diagnostic Studies: Labs, Imaging, EKG Results. Prior Outpatient Treatment Including Medications Prescribed in Last 72 Hours, Medications and /or IV fluids ordered**. If Surgery is related to Hysterectomy, Completed Form (DHHS FORM 1723) Sterilization Consent and Hysterectomy Form for Surgical Justification is required** **Please Describe Any Other Pertinent Information Related to this Prior Authorization Request**
Out of State	**Services provided out of state for circumstances other than these specified reasons shall not be covered.** 1. The medical services must be needed because of a medical emergency; 2. Medical services must be needed and the member's health would be endangered if they were required to travel to his/her state of residence; 3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; 4. It is the general practice for members in a particular locality to use medical resources in another state. 5. Service is not available within South Carolina Area of Service. See the applicable service type specific instructions above when requesting one of these services.

Required Forms can be found at: http://scdhhs.kepro.com/content/forms.aspx

15. **Intensity of Services (Proposed /Actual monitoring and therapeutic services):**
    - This is another critical area of the form. Knowledge of InterQual/SCDHHS criteria will be helpful to provide pertinent information.
    - This field should include the treatment plan for the member. List the services, procedures, or treatments that will be provided to the member.
    - Service Type specific instructions:

16. **Additional Comments:** This area must be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the Regulations, SCDHHS Manual, and InterQual criteria (see Prior Auth chapter in the SCDHHS Manuals).

17. **Procedure Code: Provide the appropriate procedure code. (ICD-9 or CPT)**
18. **Code Description:** Provide the procedure code description.
19. **Modifiers (if applicable):** Enter as applicable.
20. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services requested. Knowledge of InterQual /SCDHHS criteria will be extremely helpful.
21. **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.
22. **Contact Name**: Enter the name of the person to contact; if there are any questions regarding this fax form.
23. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
24. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial, need for additional information, or reject.

*__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.