



SC Medicaid Genetic Testing for SMA Prior Authorization Request Form

Acentra Health

Submit fax request for Prior Authorization to 1-855-300-0082

Complete all sections of the form

1. <input type="checkbox"/> Initial		<input type="checkbox"/> Continuation PA #	<input type="checkbox"/> Change PA #	<input type="checkbox"/> Cancel	*REQUIRED* CONTACT NAME: *CONTACT FAX: CONTACT PHONE:	
2. Date of Request (mm/dd/yyyy) / /			3. Review Type (check one if applicable) <input type="checkbox"/> Prior Authorization <input type="checkbox"/> Retrospective Review (Date notified of retrospective 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
9. a. NPI/Requesting Provider Name & ID Number: b. 9-digit Zip Code (Mandatory)		10. Diagnosis Codes: (enter up to 5) list primary first 1. 2. 3. 4. 5.				
11. a. NPI/Rendering FACILITY ID Number: b. 9-digit Zip Code <i>(Mandatory)</i>		12. Prior Auth Service Type: *REQUIRED* START OF CARE DATE / / <input type="checkbox"/> 81329 <input type="checkbox"/> 81336 <input type="checkbox"/> 81337				
13. Required Documentation attached: ____ Physician's order for genetic testing ____ documentation supporting members current signs and symptoms for working diagnosis, current condition or knowledge of familiar history to support genetic testing request.						

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