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. ☐ **Initial**	☐ **Continuation** **PA #**	☐ **Change** **PA #**	☐ **Cancel**	***REQUIRED*** **CONTACT NAME:** ***CONTACT FAX:** **CONTACT PHONE:**
2. **Date of Request** (mm/dd/yyyy) / /	3. **Review Type** (check one if applicable) ☐ Prior Authorization ☐ 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:** ☐ Male ☐ 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** ***(Mandatory)***	12. **Prior Auth Service Type: *REQUIRED*** **START OF CARE DATE** / / ☐ **81329** ☐ **81336** ☐ **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.**				