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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **1.  Initial** | **Continuation** | **Change** | | **Cancel** | **Continuation/Concurrent: Enter current PA#. Change or Cancel: Enter PA# to be changed.** | | **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 | | 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:**  Targeted Case Management  **T1016** **Units Requested** \_\_\_\_\_  **T1017** **Units Requested** \_\_\_\_\_ | | | **\*REQUIRED\***  **Requested Dates of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Requested Dates of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| 14**. Required Documentation attached:**  **INITIAL: CONCURRENT:**  MTCM Referral Form  Participation Agreement  Current Assessment  Service notes for last 30 days  SCDHHS TCM Brief Screening form  Freedom of Choice Form  Care Plan | | | | | | | |

**CONTACT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT PHONE NUMBER**:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT FAX: REQUIRED**: REQUIRED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSTRUCTIONS FOR MEDICAID TARGETED CASE MANAGEMENT (MTCM) ELECTRONIC FAX FORM**

This FAX submission form is required for faxed MTCM Initial Certification, Concurrent/Continued Stay reviews, and Retrospective Reviews. When submitting the fax, please be certain all required documentation is attached.

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 Healthforms 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/) (https://portal.kepro.com). **This excludes weekends and holidays.**

\***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.**