***Acentra Health, SCDHHS QIO now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) with 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***](http://zip4.usps.com/zip4/welcome.jsp)

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

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| **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**[ ]  Outpatient[ ]  Provider’s Office | 11.  **Primary Diagnosis Code/ Description: (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:**[ ]  Mental Health Counseling [ ]  Therapies (PT, OT, SP) [ ]  DME[ ]  PEER SUPPORT  | [ ]  Home Health[ ]  Hospice [ ]  Autism Spectrum Disorder    |
| 14. **Clinical Information (See instructions pertaining to each Prior Auth service type) For Mental Health Counseling, please just submit SCDHHS required forms:**      |

**Requests may be submitted up to 30 days prior to schedule procedures/services, provided Member is eligible.**

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| **Number** | **15. HCPCS/ CPT Code** | **16. Code Description** | **17. Modifiers****(if applicable)** | **18. Units Requested (If Applicable)**  | **19. Frequency** | **20. Dates of Service**  |
| **From****(mm/dd/yyyy)** | **Thru (mm/dd/yyyy)** |
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| 21. Contact Name: Contact Name: |
| 22. Contact Telephone Number:Contact Telephone Number: |
| 23. Contact Fax Number:Contact Fax Number: |

**Additional** **Information**

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| 14. Severity of Illness (For Mental Health Counseling and Autism Spectrum Disorder please just submit SCDHHS required forms)      |
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**INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM**

[**http://scdhhs.kepro.com**](http://scdhhs.kepro.com)

This FAX submission form is required for faxed outpatient Initial Certification, Recertification, and Retrospective Reviews. 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 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 (PA AUTH) 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 Connect ([http://scdhhs.kepro.com](http://dmas.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.
	* **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; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. 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 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 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. Ex: Mental Health Counseling: Mark “Outpatient”.
2. **Primary Diagnosis Code /Description:** Provide the primary diagnosis code and/or descriptionindicating the reason for service(s).
3. **a. NPI Rendering Provider Name and ID Number:** Enter the rendering provider name and National Provider Identifier (NPI) for the provider performing the service.

**b.** **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. **Prior AUTH Service Type:** Place a √ or **X** to indicate the category of service you are requesting
2. **Clinical Information :**
* Knowledge of InterQual/SCDHSS 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]).
	+ This field must include the treatment plan for the member. List the services, procedures, or treatments that will be provided to the member
	+ Service Type specific instructions:

|  |  |
| --- | --- |
| **Mental Health Counseling** | * Please submit any SCDHHS required forms which may include LIP Referral Form, LIP Authorization form, Medical Necessity Statement, and Screening tool
 |
| **DME** | * Provide Wheel Chair MCMN
* Provide Orthotic MCMN for Cranial Molding

  |
|  **Therapies*** **Physical Therapy**
* **Speech therapy**
* **Occupational Therapy**
 | * Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.
* Describe the long term and short term goals with achievement dates; Documentation of meeting program goals
 |
| **Home Health** | Describe, in detail, extenuating circumstances which make additional visits medically necessary. * Plan of Care
* Clinical Documentation supporting this request.

**Services can include:*** + - Skilled Nursing
		- Physical Therapy
		- Occupational Therapy
		- Speech Therapy
		- Home Health Aide
 |
| **Hospice**  | * Provider must submit a Plan of Care (POC) for each beneficiary, before rendering Hospice services.
* Medicaid Hospice Certification/Recertification DHHS Form 151 certifying an individual is terminally ill.
* To complete the PA process, the hospice provider must submit the following information below within 15 days (Business days) from date of election.
* Clinical Supporting Documentation
 |
| **Autism Spectrum Disorder** | Provider must submit required documents for each request:* Initial Authorization Request
	+ Comprehensive Assess/Testing Report
	+ Behavior Identification Assessment Results
	+ Individualized Plan of Care
* Continuation of Treatment Authorization Request
	+ Two most recent 90-day Summary Reports
	+ Most recent Individualized Plan of Care
* Annual Treatment Authorization Request
	+ Two most recent 90-day Summary Reports
	+ Most recent Behavior Identification Assessment Results
	+ Most recent Individualized Plan of Care
 |

**15. HCPCS/CPT:** Provide the HCPCS/CPT procedure code.

**16. Code Description:** Provide the HCPCS/CPT procedure code description.

1. **Modifiers (if applicable):** Enter modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Accessories.
2. **Units Requested**: Based on physician’s orders, plan of care, or MCMN provide the number of services/visits requested. Knowledge of InterQual/SCDHHS criteria will be extremely helpful. Place numbers only in the Units Requested block. **(If Applicable)**
3. **Frequency:** Enter Frequency usage of Service requested- (if Applicable)
4. **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.
5. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
6. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
7. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/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.**

**Appropriate CMN and Referral forms can be found at:** [**http://scdhhs.kepro.com/content/forms.aspx**](http://scdhhs.kepro.com/content/forms.aspx)