Outpatient Prior Authorization Request Form Acentra Health QIO

Acentra Health 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 <u>9 digit zip code</u> then please visit: <u>http://zip4.usps.com/zip4/welcome.jsp</u>

Submit fax request for Prior Authorization to: 1-855-300-0082 Requests may be submitted up to 30 days prior to schedule procedures/services, provided Member is eligible.

1. 🗌 Initial	Recertification	Change		Cancel	Recert: Enter PA#. Change Enter PA# to 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.			10. Treatment Setting		11. Primary Diagnosis Code/ Description: (enter up to 5)				
a. NPI/Requesting Servio	ce Provider Name & ID Nu	imber:] Outpatient	1.	2.			
b. 9 digit Zip Code (Ma	andatory)] Provider's Office	3. 5.	4.			
12.			13. P i	rior Auth Service Type:					
a. NPI/Rendering Provider Name and ID Number:				Mental Health Counseling Home Health			lth		
b. 9 digit Zip Code] Therapies (PT, OT, SP)] DME	HospiceAutism Spectrum Disorder					
						~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~			
14. Clinical Information (See	e instructions pertaining to	each Prior Auth service	type) F	or Mental Health Counseling, ple	ase just submit :	SCDHHS requi	ired forms:		

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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		
	15. HCPCS/ CPT Code					From (mm/dd/yyyy)	Thru (mm/dd/yyyy)	
1.						/ /	/ /	
2.						/ /	/ /	
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4.						/ /	/ /	
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18.						/ /	/ /	
21. Co	ontact Name:	1	I		I		.1	
22. Co	ontact Telephone	e Number:						
	ontact Telephone ontact Fax Numb							

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SC QIO OP Fax Form Revised: 11/2024

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Additional Information

14. Severity of Illness (For Mental Health Counseling and Autism Spectrum Disorder please just submit SCDHHS required forms)

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