TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

In determining whether to provide Prior Authorization, the South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions.

When submitting a completed Transplant Prior Authorization Request Form:

1. The referring South Carolina (SC) Medicaid provider must complete the form.

2. All fields on the form must be completed.

3. Include supporting clinical documentation *(e.g.,* clinical notes, diagnostic studies, lab results)

4. This is not an authorization for payment. Payments are made subject to the beneficiary's eligibility and benefits on the day of service.

5. Providers seeking reimbursement for services must be credentialed with SC Medicaid.

6. You must provide sufficient information to allow us to make a decision regarding your request.

7. If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

8. Requests for prior authorizations from KePRO may be submitted using one of the following methods.

KePRO Customer Service:	1-855-326-5219
KePRO Fax #	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

SCDHHS reserves the right to make recommendations to a center that has provided transplant services to Medicaid beneficiaries in the past. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, as these services are non-covered by SC Medicaid. In addition, a copy of the beneficiary's medical records, relating to the transplant, for up to the past year must be included.

All transplant prior authorization requests require at least 10 days advance notice.

South Carolina
Department of Health and Human Services

Post Office Box 8206
Columbia, South Carolina 29202-8206

Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification**.** Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

NAME OF BENEFICIARY: _____ DATE OF BIRTH: _____

SC MEDICAID ID#: _____

NAME OF GUARDIAN (if applicable): _____ CONTACT NUMBER: _____

REFERRING PHYSICIAN: _____

NPI: _____ _____ SC MEDICAID #: _____

TYPE OF TRANSPLANT: _____ Is the patient receiving a _____ living organ or a _____ cadaveric organ?

EXPECTED DATE OF SERVICE: _____ EXPECTED DATE OF RETURN: _____

WILL THE BENEFICARY REQUIRE TRANSPORTATION? **YES** _____ **NO** _____

RECOMMENDED MODE OF TRANSPORTATION: _____

Medicaid patients, as well as their escort, may be provided transportation when necessary. Prior approval is mandatory in order to make the necessary travel arrangements. Contact the SCDHHS Provider Service Center at 1-888-289-0709 to make travel arrangements.

RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

ADDRESS: _____

TELEPHONE: _____ FAX: _____

NAME OF CONTACT PERSON/COORDINATOR: _____

REQUIRED DOCUMENTATION

- ☐ Letter of Medical Necessity for the transplant, including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history
- ☐ Medical records, including physical exam, medical history, and family history
- ☐ Laboratory assessments including serologies
- ☐ Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) – If applicable.

PLEASE ANSWER THE FOLLOWING QUESTIONS

	Yes	No
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?		
Has the patient had active alcohol, tobacco, or substance abuse within the past 6 months?		
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post transplant care?		
Does the patient have any uncontrolled/untreatable infections or diseases?		

If the answer is "Yes" to any of the above questions, please explain and provide medical documentation.

I certify that the above information is correct and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

_____ _____
SIGNATURE OF REFERRING PHYSICIAN **DATE**