***“*KePRO/ SCDHHS now require any Medicaid Provider submitting Service Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide 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 or call KePRO Customer Service at 1-855-326-5219. Web submissions can be made at:** [**http://scdhhs.kepro.com**](http://scdhhs.kepro.com)**. Requests may be submitted up to 30 days prior to scheduled procedures/ services, provided the Member is eligible.**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. [ ]  **Initial Review**
 | [ ]  **Continued Treatment Review** | [ ]  **Retrospective Review** | [ ]  **Change Request** [ ]  **Cancel** |
| 1. **Date of request:   /  /**
 | 1. **Medicaid ID#:**

 | 1. **Last Name:**

 | 1. **First Name:**

 | 1. **Date of Birth:** **/****/**
 | 1. **Gender:**

**[ ]  Male** **[ ]  Female** |
| 1. **NPI/ Requesting Service Provider Name, Address and fax number:**

**9 digit zip code (mandatory):** | **10. DSM IV:****Axis I:** **Axis II:** **Axis III:** **Axis IV:**  |
| 1. **NPI/ Rendering Service Provider Name, Address and fax number:**

**9 digit zip code (mandatory):** |
| **11. Clinical Information:**For **Initial Review**, please submit Comprehensive Assessment along with this form.For **Continued Treatment Review**, please submit most recent treatment plan and progress summary along with this form.For **Psychological Testing & Evaluation**, please provide:Reason for testing:Referral source: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Number** | **12. HCPCS/ CPT Code** | **13. Code Description** | **14. Units Requested**  | **15. Frequency** | **16. Dates of Service (up to 6 months)** |
| **From****(mm /dd /yyyy)** | **Thru (mm /dd /yyyy)** |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |
|  |       |       |     |       |   /  /     |   /  /     |

This Prior Authorization Request form is required when requesting outpatient Initial Review, Continued Treatment Review, Retrospective Reviews, and Change or Cancel requests. When submitting, 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 KePROforms can be entered.

If KePRO 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 KePRO will be provided to you via Fax 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 Review:** Use for all newrequests. Resubmitting a request after receiving a reject would be an initial request also.
	* **Continued Treatment Review:** A request for continued services (items) beyond the expiration of the previous Prior Authorization would be a Continued Treatment request.
	* **Retrospective Review:** A request for review when Medicaid coverage has been obtained after the services were provided, and the Medicaid coverage is made retroactive active to the date of service.
	* **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. 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. **Member Medicaid ID Number:** It is the provider’s responsibility to ensure the Member’s Medicaid number is valid. This should contain 10 digits
4. **Member Last Name:** Enter the Member’s last name exactly as it appears on the Medicaid card.
5. **Member First Name:** Enter the Member’s first name exactly as it appears on the Medicaid card.
6. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
7. **Gender:** Please place a **√** or **X** to indicate the sex of the member.
8. **a. NPI/Requesting Service Provider Name, Address, and Fax number:** Enter the requesting/service provider name, address, fax number, 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. **a. NPI/Rendering Service Provider Name, Address, and Fax number:** Enter the referring provider name, address, fax number, and National Provider Identifier (NPI) for the provider requesting 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. **DSM IV Code /Description:** Provide the primary diagnosis code and/or descriptionindicating the reason for service(s).

**NOTE: First one listed will be marked as primary, unless otherwise indicated**

1. Clinical Information:
* For Initial Review, please submit comprehensive assessment along with this form
* For Continued Treatment Review, please submit most recent treatment plan and progress summary along with this form
* For Psychological Testing & Evaluation, please provide reason for testing and referral source.

12. **HCPCS/CPT:** Provider the HCPCS/CPT procedure code

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

14. **Units Requested**: Provider the number of services/visits requested. Knowledge of Interqual/SCDHHS criteria will be extremely helpful. Place numbers only in the Units requested block.

15. **Frequency**: Enter Frequency usage of Service requested.

16. **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. Prior authorizations will only be indicated for a 6 month period.