

Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
 All fields must be completed for the request to be processed.
 Please make a selection where applicable throughout the document.

DATE			
TYPE OF REQUEST	<input type="checkbox"/> URGENT	<input type="checkbox"/> STANDARD	<input type="checkbox"/> RETROSPECTIVE
TREATMENT SETTING	<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT	
REQUEST TYPE	<input type="checkbox"/> EXTENSION	<input type="checkbox"/> INITIAL	<input type="checkbox"/> CANCEL
	<input type="checkbox"/> ADDITIONAL CLINICAL	<input type="checkbox"/> DISCHARGE PLANNING	<input type="checkbox"/> CHANGES DOS/SETTING <input type="checkbox"/> OTHER
PREVIOUS AUTHORIZATION NUMBER			
CONTACT NAME			
CONTACT PHONE		CONTACT FAX	

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER		DATE OF BIRTH
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

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PROVIDER INFORMATION

PROVIDER NAME		
PROVIDER TIN	PROVIDER NPI	
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER	
PROVIDER STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <u> </u> PAR <u> </u> NON PAR <u> </u> IN CREDENTIALING		
FACILITY NAME		
FACILITY TIN	FACILITY NPI	
FACILITY PHONE NUMBER	FACILITY FAX NUMBER	
FACILITY STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <u> </u> PAR <u> </u> NON PAR <u> </u> IN CREDENTIALING		

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)		
REFERRING PHYSICIAN TIN		
REFERRING PHYSICIAN NPI		
REFERRING PHYSICIAN PHONE NUMBER		
REFERRING PHYSICIAN FAX NUMBER		
REFERRING PHYSICIAN STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <u> </u> PAR <u> </u> NON PAR <u> </u> IN CREDENTIALING		

MEDICAL SECTION

NOTES

PLEASE FAX TO 1-866-368-4562

OWNERSHIP DISCLOSURE: THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS) REQUIRES ALL PROVIDERS WHO DO NOT HAVE A SOUTH CAROLINA MEDICAID ID TO SUBMIT OWNERSHIP AND CONTROL INFORMATION, INCLUDING INFORMATION ON AGENTS OR MANAGING EMPLOYEES OF THE PROVIDER.

FOR MORE INFORMATION: A LINK TO THE SCDHHS OWNERSHIP DISCLOSURE FORM IS LOCATED ON THE SELECT HEALTH WEBSITE AT: **STATE OF SOUTH CAROLINA OWNERSHIP DISCLOSURE FORM.**

PLEASE ALSO INCLUDE A COPY OF YOUR W-9 FORM.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.

