



INPATIENT AUTHORIZATION FORM (SOUTH CAROLINA)

Initial Request/Notifications: 1-866-912-3606
Concurrent Clinicals **Fax** to 1- 866-653-6349
Behavioral Health Requests: **Fax** 1-833-493-3349

Standard Request - Determination within 14 working days of receiving all necessary information

Urgent Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

PHYSICIAN MUST SIGN FOR URGENT PRIORITY REVIEW. IF WE DO NOT HAVE THE PHYSICIAN'S SIGNATURE, IT WILL BE PROCESSED AS A STANDARD REQUEST.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First *

Date of Birth *

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name *

Requesting Provider Name

Phone *

Fax *

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name *

Servicing Provider/Facility Name

Phone*

Fax*

AUTHORIZATION REQUEST

Primary Procedure Code *

(CPT/HCPCS)

(Modifier)

Start Date OR Admission Date *

(MMDDYYYY)

Diagnosis Code *

(ICD-10)

Additional Procedure Code

(CPT/HCPCS)

(Modifier)

Discharge Date (if applicable) otherwise
Length of Stay will be based on Medical Necessity

(MMDDYYYY)

Additional Diagnosis Code

(ICD-10)

* INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

Delivery

779 C-Section Delivery

720 Vaginal Delivery

Post Acute Placement

427 Rehab

121 Long Term Acute Care

402 Skilled Nursing Facility

492 Subacute

Acute Admissions

490 Boarder Baby

970 Medical

300 Neonate

414 Premature/False Labor

411 Surgical

992 Transplant

(Check Box for Elective Inpatient Pre-Service Request)

BEHAVIORAL HEALTH

528-BH-Chemical Substance Abuse

529-BH-Psychiatric Admission

531-BH-Eating Disorders

532-BH-Crisis Stabilization Unit

535-BH-Residential Treatment-Substance Abuse

536-BH-Residential Treatment-Mental Health

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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