Healthy Connections

INPATIENT MEDICAID PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-866-912-3606

☐ Standard Request - Determination within 14 calendar days of receiving all necessary information.

For Urgent requests, please call 1-866-433-6041. *Urgent requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Determination is made within 72 hours of receiving request.*

****For providers outside of South Carolina AND non-contracting with Absolute Total Care, prior authorization is required for ALL services.**

✱INDICATES REQUIRED FIELD

MEMBER INFORMATION

Date of Birth✱ (MMDDYYYY)

Member ID/Medicaid ID ✱

Last Name, First

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)

INPATIENT SERVICE TYPE✱

(Enter the Service type number in the boxes)

Delivery

779 C-Section

720 Vaginal Delivery

Inpatient Rehab

479 Inpatient Hospital

220 Comprehensive Inpatient Rehab Facility

121 Long Term Acute Care

970 Medical

414 Premature/False Labor

402 Skilled Nursing Facility

492 Sub-Acute

411 Surgical

Transplant

209 Surgery

419 Work-up

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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