

Request for additional units. Existing Authorization Units

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

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) Additional Procedure Code (CPT/HCPCS) (Modifier) Start Date OR Admission Date * (MMDDYYYY) Diagnosis Code * (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier) Additional Procedure Code (CPT/HCPCS) (Modifier) End Date OR Discharge Date (MMDDYYYY) Total Units/Visits/Days

OUTPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes)

412 Auditory Services	709 Genetic Testing	101 Physical Therapy
401 Cardiac Pulmonary Rehab	249 Home Health	201 Sleep Study
924 Chiropractic	211 OB Ultrasound(s)	701 Speech Therapy
712 Cochlear Implants & Surgery	410 Observation (authorization required only if greater than 48 hours)	
DME	790 Occupational Therapy	724 Transportation
417 Rental <input type="text"/>	497 Office Visit/Specialty Consult	
120 Purchase (Purchase Price)	927 Outpatient Hospice	
	794 Outpatient Services	
299 Drug Testing	171 Outpatient Surgery	
922 Experimental and Investigational Procedure	202 Pain Management	

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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