Pharmacogenetic Genetic Testing Prior Authorization Request Form
KEPRO-SCDHHS QIO

KEPRO-SCDHHS QIO now requires any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) with 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

Submit fax request for Prior Authorization to: 1-855-300-0082
Requests may be submitted up to 30 days prior to scheduled procedures/services, provided Member is eligible.

1. Date of Request (mm/dd/yyyy) / /	**2. Review Type (check one if applicable)** ☐ Prior Authorization ☐ Retrospective Prepayment Review (Date notified of eligibility / /)			
3. **Member Medicaid ID Number** (10 digit Number):	4. **Member Last Name**:	5. **Member First Name:**	6. **Date of Birth** (mm/dd/yyyy): / /	7. **Gender:** ☐ Male ☐ Female
8. a. **NPI/Requesting Service Provider Name & ID Number:** b. **9 digit Zip Code (Mandatory)**	9. **Treatment Setting** ☐ Outpatient LAB	10. **Primary Diagnosis Code: (enter up to 5)** 1. 2. 3. 4. 5.		
11. a. **NPI/Rendering Provider Name and ID Number:** b. **9 digit Zip Code** ***(Mandatory)***	12. **Prior Auth Service Type:** ☐ LAB	**CPT CODE:** ☐ 81418		
13. **NPI/ORDERING Provider Name and ID Number:**				

14. Contact Name:
15. Contact Telephone Number:
16. Contact Fax Number:

****Please submit this form in addition to the medical records that support the genome testing. This may include H&P, current treatment plan and medications.**

The information contained in this facsimile is legally privileged and confidential information intended only for use of the entity named above. If the reader of this message is not the intended member, employee, or agent responsible for delivering this message, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF CONFIDENTIAL INFORMATION IS STRICTLY PROHIBITED AND COULD SUBJECT YOU TO LEGAL ACTION. If you received this in error, please notify KEPRO by phone or fax at the appropriate number listed above, and destroy the misdirected document. Thank you.

SC QIO OP Fax Form
Approved:

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INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

This FAX submission form is required for faxed Pharmacogenetic testing Reviews. When submitting the fax, 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.

If KEPRO determines that your request meets appropriate coverage criteria guidelines, the Prior Authorization (PA AUTH) number provided by KEPRO will be provided to you via Fax back process and will be available to providers registered on the web-based program Atrezzo (https:portal.kepro.com). **This excludes weekends and holidays.**

1. **Date of Request:** The date you are submitting the Prior Authorization request.
2. **Review Type:** Place a √ or **X** in the appropriate box. Requests must be received on or before services are rendered. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
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 and ID Number:** Enter the requesting/service provider name 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.
9. **Treatment Setting:** Default to OUTPATIENT/ LAB
10. **Primary Diagnosis Code /Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).
11. **a. NPI Rendering Provider Name and ID Number:** Enter the rendering provider name and National Provider Identifier (NPI) for the provider performing 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,
12. **Prior AUTH Service Type and Procedure Code:** This request for is specifically for Pharmacogenetic Testing, CPT 81418
13. **NPI Ordering Provider:** must be a board-certified psychiatrist or psychiatrist extender
14. **Contact Information** Please put the name and contact number of the person completing the request so we may contact you if we have any questions

**** Reminder: Prior Authorization is based on medical necessity and is not a guarantee of payment. Providers are responsible for checking patient eligibility and following the rules and regulations outlined in the SCDHHS provider policy and billing manuals.**

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