TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

The South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions in determining whether to provide prior authorization.

General Information

- All transplant prior authorization requests require at least 10 days advance notice.
- Ensure most recent version of the Transplant Prior Authorization Request form is submitted.
- The referring South Carolina (SC) Medicaid provider must complete the form.
- All fields on the form must be completed.
- Providers seeking reimbursement for services must be credentialed with SC Medicaid.
- Incomplete prior authorization requests are administratively denied. Requests are considered only when completed and received before the service is provided.
- Include supporting clinical documentation *(e.g.,* clinical notes, diagnostic studies, lab results)
- Authorization approval is not an authorization for payment. Payments are made based on the beneficiary's eligibility and benefits on the day of service.
- If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

Requests for prior authorizations may be submitted to Kepro using one of the following methods.

Kepro Customer Service:	1-855-326-5219
Kepro Fax #	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

BENEFICIARY INFORMATION

NAME OF BENEFICIARY: _____ SC MEDICAID #: _____DATE OF BIRTH: _____

NAME OF GUARDIAN (if applicable): _____ CONTACT NUMBER: _____

PROVIDER INFORMATION

REFERRING PHYSICIAN

NAME OF REFERRING PHYSICIAN: _____NPI: _____ SC MEDICAID #: _____

TYPE OF TRANSPLANT: _____ TYPE OF ORGAN BEING RECEIVED: Living _____ Cadaveric _____

EXPECTED DATE OF SERVICE: _____

RENDERING PHYSICIAN/FACILITY

NAME OF PHYSICIAN(S): _____ NAME OF FACILITY: _____

FACILITY NPI: _____ FACILITY SC MEDICAID #: _____

FACILITY ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

NAME OF CONTACT PERSON/COORDINATOR: _____

TELEPHONE: _____ FAX: _____

DIAGNOSIS/PROCEDURE CODES and DESCRIPTIONS

ICD-10 DIAGNOSIS CODE(S)	DESCRIPTION
PROCEDURE CODE(S)	**DESCRIPTION**

REQUIRED DOCUMENTATION

Letter of Medical Necessity for the transplant, including the following:

- Summary of course of illness, current medications, smoking, alcohol, and drug abuse history must be six months free from use.
- Medical records, including physical exam, medical history, family history and laboratory assessments including serologies
- Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) - if applicable.

I certify that the above information is correct, and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

_____ _____

SIGNATURE OF REFERRING PHYSICIAN **DATE**