SOUTH CAROLINA MEDICAID PROGRAM
CIRCUMCISION
REQUEST FOR PRIOR APPROVAL REVIEW

SEND COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:

SCDHHS
CIRCUMCISION PRIOR APPROVAL REVIEW
FAX: (803) 255-8255

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ *MEDICAID# _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE:_____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA FAX**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 02/01/11