

Patient Information:

Patient Name:	SC Medicaid Number:	Date of Birth:
Diagnosis Code:	Procedure Request:	Date of Service:

Requesting Physician Information:

Physician Name:	SC Medicaid Provider Number:	NPI Number:
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South Carolina Department of Health and Human Services (SCDHHS) Medical Necessity Criteria for Fetal DNA Blood Testing:

Please check appropriate boxes supporting request for prior authorization

- Underwent pretest counseling;
- A cell-free fetal DNA test has not been performed yet in this pregnancy;
- Current pregnancy not a multiple gestation;
- Current pregnancy greater than or equal to ten (10) weeks and less than twenty-three (23) weeks at the time the blood will be drawn
- High risk for fetal aneuploidy as evidenced by one of the following:
 - Maternal age greater than or equal to thirty-five (35) years at delivery;
 - Maternal history of a child affected with trisomy;
 - Abnormal ultrasound findings;
 - Positive test result for aneuploidy, including first trimester, sequential or integrated screen or quadruple screen;
 - A parent carrying a balanced Robertsonian translocation with increased risk of trisomy 13 or trisomy 21.

Requesting Physician Signature: _____ Date: _____

The form should be completed by the clinician who has a thorough knowledge of the member's current clinical presentation and her treatment history. Please complete all parts as clearly and specifically as possible. Omissions, generalities and illegibility will result in the form being returned, delaying requested services.

Required Documentation:

- Completed SCDHHS Prior Authorization Form for Fetal DNA Blood Test
- Medical Records/Documentation

All request submitted via fax must include supporting medical and clinical information: