SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Best Chance Network
Prior Authorization Code Request Form

To request a prior authorization (PA) code, complete this form and return it with a cover sheet. Failure to include a return fax number may delay the issuance of a PA code.

Authorization Fax Line: Toll Free: 803-898-4633 Authorization Phone Number: Toll Free: 1-866-297-6813

Provider Code*: ______________________ Date*: ______________________________ Telephone (ext)*: ____

Name of person requesting PA code*: ____ ☐ Return Fax Number*: _____________________________________

Signature of person requesting PA Code*:_____________________________________

Chart #		
MedIT #		
*Date of Service		
***First Name**		
*Last Name		
***Date of Birth**		
Social Security Number (last four digits)		
Ethnicity:	☐ Hispanic ☐ Non-Hispanic	☐ Hispanic ☐ Non-Hispanic
Race:(Check all that apply)	☐ White ☐ Black or African American ☐ Asian ☐ Pacific Islander ☐ Native American	☐ White ☐ Black or African American ☐ Asian ☐ Pacific Islander ☐ Native American
*Insurance: Does client have insurance? If yes, please indicate type: 1. Diagnostic coverage <100% 2. High deductible (>$1,000) 3. Medicare Part A 4. Medicaid Family Planning 5. Other ___________________________________	☐ **Yes** ☐ No 1 ☐ _____________ 2 ☐ _____________ 3 ☐ _____________ 4 ☐ _____________ 5 ☐ _____________	☐ **Yes** ☐ No 1 ☐ _____________ 2 ☐ _____________ 3 ☐ _____________ 4 ☐ _____________ 5 ☐ _____________
***Household Income**	$ __________ ☐ Weekly ☐ Monthly ☐ Annually	$ __________ ☐ Weekly ☐ Monthly ☐ Annually
*Household Size		
***Has a SC address** (has SC address)	☐ Yes ☐ No	☐ Yes ☐ No
*Needs BCN exam (CBE, Pap test, HPV test)	☐ Yes ☐ No	☐ Yes ☐ No
Breast symptoms?	☐ Yes ☐ No	☐ Yes ☐ No
Cervical symptoms?	☐ Yes ☐ No	☐ Yes ☐ No
*Needs screening mammogram	☐ Yes ☐ No	☐ Yes ☐ No
Needs breast diagnostic services (must include related reports). Please indicate why (CBE, mamm., u/s, high risk, etc):	☐ Yes ☐ No Why: ____________	☐ Yes ☐ No Why: ____________
Needs cervical diagnostic services (must include related reports). Please indicate why (Pap, HPV, pelvic exam, etc):	☐ Yes ☐ No Why: ____________	☐ Yes ☐ No Why: ____________

I certify under penalty of perjury that the information I have provided as an authorized, contracted provider for Best Chance Network (BCN) medical services has been obtained and verified. I understand the information I provide will be used to determine the patient's eligibility for Best Chance Network (BCN) medical services. I understand that as a contracted provider of these services, SC Department of Public Health (SC DPH) can audit or request any eligibility or supporting documents, to verify that the patient meets the eligibility requirements.

Confidentiality Notice

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