South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

PRIVATE DUTY NURSING/EXTENDED HOME HEALTH AIDE PRIOR AUTHORIZATION REQUEST FORM

Form **must be** submitted with current plan of care signed by a physician.

Date:		
RECIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex: M ☐ F ☐**
Last Name:	**First Name:**	
GENERAL INFORMATION		
Private Duty Nursing: ☐	**Extended Home Health Aide:** ☐	
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code(s):		
Procedure Code(s):	**Quantity:**	
Procedure Description:		
Number of Hours Per Week:	**RN** **LPN** **HH Aide**	

POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed Point of Contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
ACCEPTING/SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

List the number of adult caretakers in the home:

For each caretaker listed above, list the number of hours employed or at school outside of the home per week:

If more than 1 adult caretaker, list the total number of hours that ALL caretakers are typically employed or at school outside the home at the same time (do not include hours the child is in school):

Additional notes about parent/guardian's schedule and needs:

Note: Hours of employment or school should include typical travel times to and from employment/school.