



OUT OF STATE PRIOR AUTHORIZATION REQUEST FORM

Form must be *submitted with medical records* to support out of state services.

Date:		State:	
GENERAL INFORMATION			
Choose Service Type: (Select all that apply)			
<input type="checkbox"/> Inpatient	Admit Date:	Anticipated Discharge Date:	
<input type="checkbox"/> Outpatient	Appointment Date:	<input type="checkbox"/> To be scheduled	
Specify Facility/Clinic Name:			
Primary Diagnosis Code:		Secondary Diagnosis Code(s):	
CPT/Billing Code(s):	Anticipated Care Needs (For example; follow up in 6 months or surgery with a 3 month follow up):		
Procedure Description:			
RECIPIENT INFORMATION			
Medicaid ID:		Date of Birth:	Sex: M F
Last Name:		First Name:	
PROVIDER INFORMATION			
Referring Provider Name:			
Referring Provider NPI:		Referring Provider Taxonomy:	
Fax:		Phone:	
Accepting/Serviceing Provider Name:			
Address:			
Accepting/Serviceing NPI:		Accepting/Serviceing Taxonomy:	
Fax:		Phone:	

EXPLANATION OF PROBLEM: Provide an explanation of the particular problem resulting from the diagnosis which relates to this prior authorization request.

IS THE ACCEPTING PROVIDER ENROLLED WITH SD MEDICAID? YES NO

IF THE ACCEPTING PROVIDER IS NOT ENROLLED, ARE THEY WILLING TO ENROLL WITH SD MEDICAID?
YES NO

ARE THERE ADEQUATE SERVICES AVAILABLE TO MEET THESE NEEDS IN SD OR A CLOSER LOCATION TO SD?
YES NO

IF YES, WHERE:

IF YES, PLEASE PROVIDE AN EXPLANATION ON NECESSITY FOR SERVICES AT THIS LOCATION:

HAS THIS RECIPIENT BEEN SEEN BY THE SERVICING PROVIDER BEFORE?
YES NO

IF YES, WHEN?

IF YES, FOR WHAT PROBLEM?

POINT OF CONTACT	
Point of Contact Name and Title:	
Fax:	Phone:
<i>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.</i>	