DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-2632
WEB: dss.sd.gov
Email: DSSMedicaidpa@state.sd.us

DSS
Strong Families - South Dakota's Foundation and Our Future

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

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

Date:		
GENERAL INFORMATION		
Private Duty Nursing	**Extended Home Health Aide**	
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
RECIPIENT INFORMATION		
Medicaid ID (9 digits):	**Date of Birth:**	**Sex:** ☐ M ☐ F
Last Name:	**First Name:**	
PROVIDER INFORMATION		
Referring Provider Name:		
Referring Provider NPI:	**Referring Provider Taxonomy:**	
Address:		
Point of Contact Name and Title:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		
Servicing Provider Name:		
Servicing Provider NPI:	**Servicing Provider Taxonomy:**	
Fax:	**Phone:**	
Number of Hours Per Week: **RN** **LPN** **HH Aide**		

Parent/Guardian's Schedule and Needs:

☐ **I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required.**

Provider name ***(please print)*****_____**

Provider Signature_____Date_____