



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

**DURABLE MEDICAL EQUIPMENT AND MEDICAL NUTRITION  
PRIOR AUTHORIZATION REQUEST FORM**

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

**NOTE: ALL FIELDS ARE REQUIRED**

<b>Date:</b>		
<b>GENERAL INFORMATION</b>		
<b>Durable Medical Equipment:</b>		
<b>Medical Nutrition:</b>		
<b>First Date of Service:</b>	<b>Last Date of Service:</b>	
<b>Primary Diagnosis Code:</b>	<b>Secondary Diagnosis Code(s):</b>	
<b>Procedure Code(s):</b>	<b>Quantity:</b>	
<b>Procedure Description:</b>		
<b>RECIPIENT INFORMATION</b>		
<b>Medicaid ID: (9 digits)</b>	<b>Date of Birth:</b>	<b>Sex:</b> M    F
<b>Last Name:</b>	<b>First Name:</b>	
<b>PROVIDER INFORMATION</b>		
<b>Referring Provider Name:</b>		
<b>Referring Provider NPI:</b>	<b>Referring Provider Taxonomy:</b>	
<b>Address:</b>		
<b>Point of Contact Name and Title:</b>		
<b>Fax:</b>	<b>Phone:</b>	
<i>Note: The determination notice will be sent to the listed Point of Contact.</i>		
<b>Servicing Provider Name:</b>		
<b>Servicing Provider NPI:</b>	<b>Servicing Provider Taxonomy:</b>	
<b>Fax:</b>	<b>Phone:</b>	

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

**HOW LONG IS THIS PROBLEM EXPECTED TO LAST?**

\_\_\_\_\_ MONTHS                      INDEFINITELY                      PERMANENTLY

I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required. There is no other equally effective treatment available which is more conservative or substantially less costly (ARSD 67:16:01:06.02). All other treatment to correct this problem has been exhausted.

**PHYSICIAN'S NAME:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

<b>REQUIRED FOR NUTRITIONAL THERAPY REQUESTS ONLY:</b>		
<b>Is this the individual's sole source of nutrition?</b>	Yes	No
<b>Does the individual reside at home?</b>	Yes	No
<b>Nutrition being Prescribed:</b>		
<b>REQUIRED FOR DURABLE MEDICAL EQUIPMENT REQUESTS ONLY:</b>		
<b>Equipment being Prescribed:</b> (Include identifying information such as brochures and pictures)		
<b>Explanation of the Equipment's Function:</b>		
<b>Purchase Price: \$</b>	<b>Rental Price: \$</b>	