DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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DSS
Strong Families - South Dakota's Foundation and Our Future

PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
GENERAL INFORMATION		
Inpatient Hospital:		
Medical/Surgical:		
Mental Health:		
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:	**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:**	

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

PROGNOSIS:

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:** _____