



DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF MEDICAL SERVICES
 700 GOVERNORS DRIVE
 PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-5246
WEB: dss.sd.gov

PRIOR AUTHORIZATION REQUEST FORM

DATE:

Durable Medical Equipment:

Home Health:

Inpatient Hospital:

Medical Nutrition:

Medical Surgical:

Mental Health:

Out of State

Synagis

First Date of Service: _____ **Last Date of Service:** _____

Estimated Length of Stay: _____

GENERAL INFORMATION

Recipient Medicaid ID# (9 digits)	Last Name	First Name	Date of Birth
			Sex: M F
Primary Diagnosis Code	Procedure Code(s)	Procedure Description	Quantity
Secondary Diagnosis Code(s)			

PROVIDER INFORMATION

Requesting Provider Name:

Requesting Provider NPI#

Requesting Provider Taxonomy#

Address

Fax#

Phone#

E-Mail

Servicing Provider Name:

Servicing Provider NPI#

Servicing Provider Taxonomy#

Referring Provider Name:

Referring Provider NPI#

Referring Provider Taxonomy#

Fax#

Phone#

E-Mail

EXPLANATION OF PROBLEM: 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?

of 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

Required for Nutritional Therapy requests only:

IS THIS THE INDIVIDUAL'S SOLE SOURCE OF NUTRITION? YES NO

DOES THIS INDIVIDUAL RESIDE AT HOME? YES NO

NUTRITION BEING PRESCRIBED:

Required for Private Duty Nursing requests only:

NUMBER OF HOURS PER WEEK: RN LPN HH Aid

PARENT/GUARDIAN'S SCHEDULE AND NEEDS:

