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

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

PRIOR AUTHORIZATION REQUEST FORM

DATE:

☐ **Durable Medical Equipment:** **Choose Type of DME**
☐ **Home Health:** **Select Type Below**
☐ **Inpatient Hospital:** **Select Inpatient Unit**
☐ **Medical Nutrition:** **Enteral or Parenteral Nutrition**
☐ **Medical Surgical:** **Select a Service Type**
☐ **Mental Health:** **Select Service Type**
☐ **Synagis**

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

GENERAL INFORMATION

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

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#

CERTIFICATE OF MEDICAL NECESSITY

Recipient Name:

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 PRESCIBED:

Required for Durable Medical Equipment requests only:

MEDICAL NECESSITY / JUSTIFICATION FOR PURCHASE OR CONTINUED RENTAL:

EQUIPMENT BEING PRESCRIBED:

EXPLANATION OF THE EQUIPMENT'S FUNCTION: (to include identifying information such as brochures and pictures)

$** **$
Purchase Price **Rental Price**

Required for Synagis requests only:

Recipient Name:

Synagis is covered by the South Dakota Medicaid Program when a child meets one of the following criteria **and it has been recommended by a Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist**:

☐ A Children under 6 months of age at the onset of the RSV season who were 35 weeks and less gestational age at birth.

☐ B Children under two years of age at the onset of the RSV season with evidence of ongoing lung disease such as bronchopulmonary dysplasia or cystic fibrosis requiring treatment with oral bronchodilators, supplemental oxygen, diuretics, or nebulized or inhaled medications to stabilize the disease in the last 6 months.

☐ C Children under two years of age at the onset of the RSV season with immunodeficiences that may make them more susceptible to severe lower respiratory tract disease related to RSV.

☐ D Any child under two years of age at the onset of the RSV season felt to be at high risk for significant lower respiratory tract illness related to RSV.

DIAGNOSIS:

HOSPITALIZATIONS/TREATMENT/MEDICATIONS USED IN THE LAST 6 MONTHS:

GESTATIONAL AGE AT BIRTH:

NEONATOLOGIST, PEDIATRIC PULMONOLOGIST, OR PEDIATRIC CARDIOLOGIST:

(*REQUIRED)*

Printed Name:

Signature:

(Both physician signatures are required.)

PRESCRIBING PHYSICIAN: *(REQUIRED)*

Printed Name:

Signature: