South Dakota Department of Social Services
Strong Families - South Dakota's Foundation and Our Future

DEPARTMENT OF SOCIAL SERVICES
EBT and NEMT
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NEMT PRIOR AUTHORIZATION REQUEST FORM

This information is requested for travel-related services for recipients with Medicare or other private health insurance in addition to SD Medicaid.

THIS FORM *MUST* BE SUBMITTED WITH MEDICAL RECORDS.

Date:	**State:**		
RECIPIENT INFORMATION			
Medicaid ID:	Date of Birth:	Sex: ☐ M ☐ F	
Last Name:	First Name:	MI:	Suffix:

GENERAL INFORMATION

Choose Service Type (select all that apply):

☐ Inpatient Admit Date: _____ Anticipated Discharge Date:_____

☐ Outpatient Appointment Date(s): _____

☐ To Be Scheduled - Tentative Date(s): _____

Specify Facility/Clinic Name & NPI:

Specialty Provider(s) (please check all that apply):

☐Allergy/Immunology	☐Genomics	☐Orthopedics
☐Cardiology	☐Infectious Disease	☐Physical. Med/Rehab
☐Dermatology	☐Nephrology/Urology	☐Pulmonology
☐Endocrinology	☐Neurology	☐Rheumatology
☐ENT/Audiology	☐Oncology	☐Transplant
☐Gastroenterology	☐Ophthalmology	☐Other: _____

Primary Diagnosis Code(s):

CPT/Billing Code(s)	**Anticipated Care Needs:** (Example: Follow up in 6 months or surgery with a 3 month follow up)

Procedure Description:

Explanation of Problem and Prognosis:

Provide an explanation of the particular problem resulting from the diagnosis which relates to this prior authorization request.

REFERRING PROVIDER INFORMATION	
Name:	
NPI #:	Taxonomy:
Phone:	Fax:

ACCEPTING/SERVICING PROVIDER INFORMATION	
Name:	
Address:	
NPI #:	Taxonomy:
Phone:	Fax:

IS THE ACCEPTING PROVIDER ENROLLED WITH SD MEDICAID? YES: ☐ NO: ☐
IF ***NO***, IS THE ACCEPTING PROVIDER WILLING TO ENROLL WITH SD MEDICAID? YES:☐ NO: ☐

HAS THIS RECIPIENT BEEN SEEN BY THE SERVICING PROVIDER BEFORE? YES: ☐ NO: ☐
IF ***YES***, WHEN?
IF ***YES***, FOR WHAT PROBLEM?

AVAILABILITY OF IN-STATE SERVICES
(If the travel request is IN-STATE, you can just leave this section blank.)

ARE THERE ADEQUATE SERVICES AVAILABLE TO MEET THESE NEEDS IN SOUTH DAKOTA OR A CLOSER LOCATION TO SOUTH DAKOTA? YES: ☐ NO: ☐

IF ***YES***, WHERE: _____

IF ***YES***, PLEASE PROVIDE AN EXPLANATION ON NECESSITY FOR SERVICES AT THIS LOCATION:

POINT OF CONTACT
The point of contact is the individual completing the form.

Name and Title:		
Email	Phone:	Fax:

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:** _____

Note: The Department may contact the listed Point of Contact if additional information or documents are needed. A separate Prior Authorization (PA) may still be required by SD Medicaid for medical services.