DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE SECRETARY
ELECTRONIC BENEFITS TRANSFER
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DSS
Strong Families - South Dakota's Foundation and Our Future

NEMT OUT OF STATE TRAVEL APPROVAL REQUEST FORM

This information is being requested for transportation services only
This information is requested for Medicaid recipients who also have Medicare

Date:	**State:**	
GENERAL INFORMATION		
Choose Service Type: (Select all that apply) ☐ Inpatient ☐ Outpatient ☐ Physician		
Specify Facility/Clinic Name:		
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: (9 digits)	**Date of Birth:**	**Sex:** ☐ M ☐ F
Last Name:	**First Name:**	
PROVIDER INFORMATION		
Referring Provider Name:		
Referring Provider NPI:	**Referring Provider Taxonomy:**	
Address:		

Accepting/Servicing Provider Name:	
Accepting/Servicing NPI:	**Accepting/Servicing Taxonomy:**
Fax:	**Phone:**

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

IS THE ACCEPTING PROVIDER ENROLLED WITH SD MEDICAID? YES NO

IF NO, ARE THEY WILLING TO ENROLL WITH SD MEDICAID? YES NO

ARE ADEQUATE SERVICES AVAILABLE IN SD OR A CLOSER LOCATION TO SD? YES NO

IF YES, WHERE:

IF NO, PLEASE PROVIDE AN EXPLANATION ON NECESSITY FOR SERVICES AT THIS LOCATION AND ATTACH MEDICAL RECORDS/DOCUMENTATION SHOWING MEDICAL NECESSITY:

HAS THIS RECIPIENT BEEN SEEN BY THE SERVICING PROVIDER BEFORE? YES NO

IF YES, WHEN?

FOR WHAT PROBLEM?

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: _____