DSS-NEMT-954 06/21

South Dakota Department of Social Services

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NEMT OUT OF STATE TRAVEL APPROVAL REQUEST FORM

This information is being requested for travel 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:	
Specialty Provider/s (please check all that apply):	
☐ Neurology ☐ Orthopedics ☐ Nephrology	
☐ Genomics ☐ Physical Medicine/Rehab ☐ Urology	
☐ Ophthalmology ☐ Rheumatology ☐ Dermatology	
☐ Oncology ☐ Sleep Medicine ☐ ENT/Audiology	
☐ Endocrinology ☐ Cardiology ☐ Pulmonology	
☐ Allergy/Immunology ☐ Infectious Disease ☐ Gastroenterology	
First Date of Service:	
Last Date of Service:	
Primary Diagnosis Code:	
Secondary Diagnosis Code(s):	
Procedure Codes(s):	
Quantity:	
Procedure Description:	
RECIPIENT INFORMAITON	
Medicaid ID Number (9 digits):	
Date of Birth:	
Sex: ☐ M ☐ F	
Last Name:	
First Name:	
PROVIDER INFORMATION	
Referring Provider Name:	
Referring Provider NPI:	

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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, is the accepting provider willing to enroll with SD Medicaid?	☐ Yes ☐ No
Are adequate services available in SD or a closer location to SD?	☐ Yes ☐ No
If yes, list the facility name and address:	
If no, 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, please list the date the recipient was seen and for what problem. - Date: - For What Problem:	

Continue to the next page

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: _____