

**MEDICAL NUTRITION PRIOR AUTHORIZATION  
 REQUEST FORM**

Form must be *submitted with medical records* to support services.  
**NOTE: ALL FIELDS ARE REQUIRED**

<b>Date:</b>		
<b>GENERAL INFORMATION</b>		
<b>Medical Nutrition:</b>		
<b>First Date of Service:</b>		<b>Last Date of Service:</b>
<b>Primary Diagnosis Code:</b>	<b>Secondary Diagnosis Code(s):</b>	
<b>Procedure Code(s):</b>	<b>Quantity:</b>	
<b>Procedure Description:</b>		
<b>RECIPIENT INFORMATION</b>		
<b>Medicaid ID: (9 digits)</b>	<b>Date of Birth:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Last Name:</b>	<b>First Name:</b>	
<b>PROVIDER INFORMATION</b>		
<b>Referring Provider Name:</b>		
<b>Address:</b>		
<b>Point of Contact Name and Title:</b>		
<b>Fax:</b>	<b>Phone:</b>	
<i>Note: The determination notice will be sent to the listed Point of Contact.</i>		
<b>Servicing Provider Name:</b>		
<b>Servicing Provider NPI:</b>	<b>Servicing Provider Taxonomy:</b>	
<b>Fax:</b>	<b>Phone:</b>	

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

**HOW LONG IS THIS PROBLEM EXPECTED TO LAST?**

\_\_\_\_\_MONTHS       INDEFINITELY       PERMANENTLY

REQUIRED FOR NUTRITIONAL THERAPY REQUESTS ONLY:		
Is this the individual's sole source of nutrition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the individual reside at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nutrition being Prescribed:		

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:** \_\_\_\_\_