



PRIOR AUTHORIZATION REQUEST FORM

Form must be *submitted with medical records* to support services.

Date:		
GENERAL INFORMATION		
Inpatient Hospital:		
Medical/Surgical:		
Mental Health:		
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:	Date of Birth:	Sex: M F
Last Name:	First Name:	
PROVIDER INFORMATION		
Referring Provider Name:		
Referring Provider NPI:	Referring Provider Taxonomy:	
Address:		
Point of Contact Name and Title:		
Fax:	Phone:	
<i>Note: The determination notice will be sent to the listed Point of Contact.</i>		
Servicing Provider Name:		
Servicing Provider NPI:	Servicing Provider Taxonomy:	
Fax:	Phone:	

EXPLANATION OF PROBLEM AND PROGNOSIS: 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?

_____ 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:** _____