



DURABLE MEDICAL EQUIPMENT PRIOR AUTHORIZATION REQUEST FORM

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

NOTE: ALL FIELDS ARE REQUIRED

Date:		
GENERAL INFORMATION		
Durable Medical Equipment:		
Medical Nutrition:		
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: <input type="checkbox"/> M <input type="checkbox"/> F
Last Name:	First Name:	
PROVIDER INFORMATION		
Referring Provider Name:		
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.

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:** _____

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:	
REQUIRED FOR DURABLE MEDICAL EQUIPMENT REQUESTS ONLY:	
Equipment being Prescribed: (Include identifying information such as brochures and pictures)	
Explanation of the Equipment's Function:	

Manufacturer: _____

Serial #: _____

Purchase Price: \$

Rental Price: \$