DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES 700
GOVERNORS DRIVE
PIERRE, SD 57501-2291
EMAIL: DSSMedicaidPA@state.sd.us
PHONE: 605-773-3495
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South Dakota Department of Social Services

OUT OF STATE PRIOR AUTHORIZATION REQUEST FORM

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

Date:	**State:**	
GENERAL INFORMATION		
Choose Service Type: (Select all that apply) ☐ Inpatient Admit Date: Anticipated Discharge Date:		
☐ Outpatient	Appointment Date: ☐ To be scheduled	
Specify Facility/Clinic Name:		
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
CPT/Billing Code(s):	**Anticipated Care Needs (For example; follow up in 6 months or surgery with a 3 month follow up):**	
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:**	
Fax:	**Phone:**	
Accepting/Servicing Provider Name:		
Address:		
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 THE ACCEPTING PROVIDER IS NOT ENROLLED, ARE THEY WILLING TO ENROLL WITH SD MEDICAID?

☐ YES ☐ NO

ARE THERE ADEQUATE SERVICES AVAILABLE TO MEET THESE NEEDS IN SD OR A CLOSER LOCATION TO SD?

☐ YES ☐ NO

IF YES, WHERE:

IF YES, PLEASE PROVIDE AN EXPLANATION ON NECESSITY FOR SERVICES AT THIS LOCATION:

HAS THIS RECIPIENT BEEN SEEN BY THE SERVICING PROVIDER BEFORE?

☐ YES ☐ NO

IF YES, WHEN?

IF YES, FOR WHAT PROBLEM?

POINT OF CONTACT	
Point of Contact Name and Title:	
Fax:	**Phone:**
Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA.	