Incontinence Prior Authorization Form

HOPE WAIVER – Fax to 605-773-7562

This form must be submitted with Medical records to support services. To find level of care please refer to the "Look-up Level of Care" guidance found on the DSS website.

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:**	**Sex:** ◉ M ○ F
Last Name:	**First Name:**	
Level of Care:		
GENERAL INFORMATION		
Date service limit exceeded:	**Last Date of Service:**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
Procedure Description:		
PROVIDER INFORMATION		
Servicing Provider Name:		
Point of Contact Name and Title:		
Servicing Provider NPI:	**Servicing Provider Taxonomy:**	
Address:		
Fax:	**Phone:**	
Referring Provider Name:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		

South Dakota Department of Social Services

Certificate of Medical Necessity

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:** ___/____/____	**Sex:** ◯ M ◉ F
First Name:	**Last Name:**	
PRESCRIBING PROVIDER INFORMATION		
Provider Name:		
Provider Signature:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
GENERAL MEDICAL INFORMATION		
Start Date of Service: ___/___/____	**End Date of Service:** ___/___/____ ☐ **Indefinitely**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Diagnosis, Prognosis, and Medical Necessity: Provide a description of the condition/diagnosis, prognosis, and a justification of the medical necessity of the equipment.		
DME PROVIDER INFORMATION		
Provider Name:		
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
SUPPLIES INFORMATION		
Description and Function of Supplies: (including HCPCS)		
Estimated number of Units:	**Price per unit:**	
Manufacturer:		

This form meets the requirements for South Dakota Medicaid found in ARSD 67:16:29:04.02.

South Dakota Department of Social Services