DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES 700
GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
WEB: dss.sd.gov
EMAIL: DSSMedicaidPA@state.sd.us

MEDICAL NUTRITION PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
GENERAL INFORMATION		
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:** ☐ M ☐ F
Last Name:	**First Name:**	
PROVIDER INFORMATION		
Referring Provider Name:		
Address:		
Point of Contact Name and Title:		
Fax:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		
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

REQUIRED FOR NUTRITIONAL THERAPY REQUESTS ONLY:		
Is this the individual's sole source of nutrition?	☐ Yes	☐ No
Does the individual reside at home?	☐ Yes	☐ 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:** __________