

Incontinence Prior Authorization Form

FAMILY SUPPORT 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:	
<i>Note: The determination notice will be sent to the listed Point of Contact.</i>		

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: ___/___/___	<input type="checkbox"/> 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:			