DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-2632
WEB: dss.sd.gov

PRIOR AUTHORIZATION REQUEST FORM

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

<table>
<tr><td colspan="3">Date:</td></tr>
<tr><th colspan="3">GENERAL INFORMATION</th></tr>
<tr><td colspan="3">Inpatient Hospital:</td></tr>
<tr><td colspan="3">Medical/Surgical:</td></tr>
<tr><td colspan="3">Mental Health:</td></tr>
<tr><td>First Date of Service:</td><td colspan="2">Last Date of Service:</td></tr>
<tr><td>Primary Diagnosis Code:</td><td colspan="2">Secondary Diagnosis Code(s):</td></tr>
<tr><td>Procedure Code(s):</td><td colspan="2">Quantity:</td></tr>
<tr><td colspan="3">Procedure Description:</td></tr>
<tr><th colspan="3">RECIPIENT INFORMATION</th></tr>
<tr><td>Medicaid ID:</td><td>Date of Birth:</td><td>Sex: M F</td></tr>
<tr><td>Last Name:</td><td colspan="2">First Name:</td></tr>
<tr><th colspan="3">PROVIDER INFORMATION</th></tr>
<tr><td colspan="3">Referring Provider Name:</td></tr>
<tr><td>Referring Provider NPI:</td><td colspan="2">Referring Provider Taxonomy:</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td colspan="3">Point of Contact Name and Title:</td></tr>
<tr><td>Fax:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="3">Note: The determination notice will be sent to the listed Point of Contact.</td></tr>
<tr><td colspan="3">Servicing Provider Name:</td></tr>
<tr><td>Servicing Provider NPI:</td><td colspan="2">Servicing Provider Taxonomy:</td></tr>
<tr><td>Fax:</td><td colspan="2">Phone:</td></tr>
</table>

EXPLANATION OF PROBLEM AND PROGNOSIS: Provide an explanation of the particular problem resulting from the diagnosis which relates to this prior authorization request.

PROGNOSIS:

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:**__________