DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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DSS
Strong Families - South Dakota's Foundation and Our Future

GENETIC TESTING PRIOR AUTHORIZATION REQUEST FORM

Form must be ***submitted with medical records*** to support medical necessity.
Please submit this form and all medical records to the email listed above.

Date:	**Anticipated Date of Service:**	
GENERAL INFORMATION		
Specify Facility/Clinic Name:		
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	
Procedure Code(s):	**Quantity:**	
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:**	
Address:		
Point of Contact Name and Title:		
Email:	**Phone:**	
Note: The determination notice will be sent to the listed Point of Contact.		
Accepting/Servicing Provider Name:		
Accepting/Servicing NPI:	**Accepting/Servicing Taxonomy:**	
Email:	**Phone:**	

WHAT THERAPIES AND MEDICATIONS ARE CURRENTLY IN PLACE?
(Please attach results of all diagnostic testing. For example, labs, biopsy, pathology, x-rays, etc.)

IF SCHOOL AGE, DOES THE CHILD CURRENTLY HAVE A CARE PLAN/IEP? ☐ **YES** ☐ **NO**
(If yes, please include a copy of child's Care Plan/IEP)

How will the outcome of the genetic testing affect the recipient's plan of care if the results are positive or negative? (Please be specific, for example: List medications that will be added or discontinues, specific therapy or procedures needed that will be associated with positive or negative results, or further screening or diagnostic testing that would be needed and has not already been evaluated.)

Percentage of prevalence of this suspected condition in the population?

Likelihood that this recipient has the condition (percentage of risk)?

☐ **I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required.**

Provider name ***(please print)***_____

Provider Signature_____**Date**_____