**DEPARTMENT OF SOCIAL SERVICES**
DIVISION OF MEDICAL SERVICES
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3495
Fax: (605) 773-5246
medical@state.sd.us

DATE: _____

## GENERAL PRIOR AUTHORIZATION REQUEST FORM

Please Check box:

**Hospital**
- ☐ Long Term Care Hospital
- ☐ NICU
- ☐ Psychiatric
- ☐ Rehabilitation
- ☐ Specialty

**Physician**
- ☐ Medical Surgical

**Psychological**
- ☐ Inpatient Psychiatric Facility
- ☐ Residential

**Home Care Services**
- ☐ Private Duty Nursing
- ☐ Durable Medical Equipment
- ☐ Extended Home Health Aide
- ☐ Medication
- ☐ Nutrition

☐ **EPSDT** ☐ **Other**

First date of service _____ Last date of service _____

**GENERAL INFORMATION**

| Recipient. Number–9 digits | Last Name | First Name | Date of Birth<br>Sex: |
|---|---|---|---|
| | | | |
| **Diagnosis Code** | **Procedure Code** | **Procedure Description** | **Quantity** |
| | | | |

**EXPLANATION OF NECESSITY FOR PROCEDURES** (Attach supporting x-rays, lab reports, operative reports, and discharge summaries etc. if indicated)

**PROVIDER INFORMATION**

Medical Assistance Provider Number _____

I certify that the information given in this form is a true and accurate medical indication for the procedures required. All other treatment to correct this problem has been exhausted.

_____ _____
Provider Signature Date

Provider Name: _____

Address: _____

_____

Provider Phone #_____ Fax #_____ E-Mail _____