South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

PHONE: 605-773-3495 | **FAX:** 605-773-5246
WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
RECIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
Inpatient Hospital:		
Medical/Surgical:		
Mental Health:		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code(s):		
Procedure Code(s):	**Quantity:**	
Procedure Description:		
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 the problem expected to last? _____ Months ☐ Unknown ☐ Permanently		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed Point of Contact.*		

REFERRING PROVIDER INFORMATION	
Name:	
NPI #:	**Taxonomy:**
Phone:	**Fax:**

SERVICING PROVIDER INFORMATION	
Name:	
Address:	
NPI #:	**Taxonomy:**
Phone:	**Fax:**