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

DURABLE MEDICAL EQUIPMENT PRIOR AUTHORIZATION REQUEST FORM

Form **must be** submitted with medical records to support services. All fields are required.

Date:		
RECIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
Durable Medical Equipment: Select Type of DME		
Medical Nutrition : Select Type		
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:**

REQUIRED FOR NUTRITIONAL THERAPY REQUESTS ONLY:		
Is this the individual's sole source of nutrition?	☐Yes	☐No
Does the individual reside at home?	☐Yes	☐No
Nutrition being prescribed:		

REQUIRED FOR DURABLE MEDICAL EQUIPMENT REQUESTS ONLY:	
Equipment Being Prescribed: (Include identifying information such as brochures and pictures)	
Explanation of Equipment's Function(s):	
Manufacturer:	**Serial Number:**
Purchase Price: $	**Rental Price: $**