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

OUT OF STATE PRIOR AUTHORIZATION REQUEST FORM

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

Date:	**State:**	
RECIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		

Choose Service Type: (Select all that apply)

☐ Inpatient Admit Date: Anticipated Discharge Date:

☐ Outpatient Appointment Date: To Be Scheduled: ☐

Specify Facility/Clinic Name & NPI:

Specialty Provider(s) (please check all that apply):

☐ Allergy/Immunology	☐ Cardiology	☐ Dermatology	☐ Endocrinology	☐ ENT/Audiology
☐ Gastroenterology	☐ Genomics	☐ Infectious Disease	☐ Nephrology/Urology	☐ Neurology
☐ Oncology	☐ Ophthalmology	☐ Orthopedics	☐ Physical. Med/Rehab	☐ Pulmonology
☐ Rheumatology	☐ Transplant	☐ Other:		

Primary Diagnosis Code(s):

CPT/Billing Code(s):	**Anticipated Care Needs:** (Example: Follow up in 6 months or surgery with a 3 month follow up)

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.

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:**

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

IS THE ACCEPTING PROVIDER ENROLLED WITH SD MEDICAID? **YES:** ☐ **NO:** ☐

IF ***NO***, IS THE ACCEPTING PROVIDER WILLING TO ENROLL WITH SD MEDICAID? **YES:** ☐ **NO:** ☐

HAS THIS RECIPIENT BEEN SEEN BY THE SERVICING PROVIDER BEFORE? **YES:** ☐ **NO:** ☐

IF ***YES***, WHEN?

IF ***YES***, FOR WHAT PROBLEM?

AVAILABILITY OF IN STATE SERVICES

ARE THERE ADEQUATE SERVICES AVAILABLE TO MEET THESE NEEDS IN SOUTH DAKOTA OR A CLOSER LOCATION TO SOUTH DAKOTA? **YES:** ☐ **NO:** ☐

IF ***YES***, WHERE:

IF ***YES***, PLEASE PROVIDE AN EXPLANATION ON NECESSITY FOR SERVICES AT THIS LOCATION: