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

GENETIC TESTING PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
RECIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
Specify Facility/Clinic Name:		
Anticipated Date of Service:		
Primary Diagnosis Code(s):		
Procedure Code(s):	**Quantity:**	
Procedure Description:		
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:**	

What therapies and medications are currently in place?
(Please attach results of all diagnostic testing. For example: Labs, biopsies, pathology reports, 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 discontinued, 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)? _____%