

DEPARTMENT OF SOCIAL SERVICES

South Dakota
Department of
Social Services

DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
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Waiver Recipient Incontinence Prior Authorization Form

This form must be submitted with medical documentation as outlined in the [DMEPOS manual](#).

| | | | |
|--|-------------|-----------------------------|----------------|
| Date: | | Last date seen by provider: | |
| Date Service Limit was Exceeded: | | | |
| Recipient Information | | | |
| Medicaid ID: | DOB: | Sex (circle one): | Male Female |
| Last Name: | First Name: | Level of Care: | |
| Prescribing Provider Information | | | |
| NPI: | | Taxonomy: | |
| Name: | | Mailing Address: | |
| Phone: | | Fax: | |
| Point of Contact Name: | | Provider Signature: | |
| DME Provider Information | | | |
| NPI: | | Taxonomy: | |
| Name: | | Mailing Address: | |
| Phone: | | Fax: | |
| Email: | | | |
| Supplies Information | | | |
| Description and Function of Supplies (including HCPCS, estimated number of units <u>per month</u> , and price per unit): | | | |