



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 <input type="checkbox"/> F <input type="checkbox"/>
Last Name:	First Name:	
GENERAL INFORMATION		
Durable Medical Equipment:		
Medical Nutrition :		
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 <input type="checkbox"/> Unknown <input type="checkbox"/> Permanently		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<i>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.</i>		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	

SERVICING PROVIDER INFORMATION

Name:	
Address:	
NPI #:	Taxonomy:
Phone:	Fax:

REQUIRED FOR NUTRITIONAL THERAPY REQUESTS ONLY:
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Is this the individual's sole source of nutrition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the individual reside at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nutrition being prescribed:		

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

PHYSICIAN SIGNATURE

<input type="checkbox"/> I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required. There is no other equally effective treatment available which is more conservative or substantially less costly (ARSD 67:16:01:06.02). All other treatment to correct this problem has been exhausted.	
Name (Printed):	
Signature:	Date: