

Medical Prior Authorization Request

Please complete, sign and date this form. Submit all supporting clinical information to Utilization Management and fax to (605) 328-6813.

Patient Information	
Member Name:	Address:
Member ID #:	City:
DOB:	State:
Phone Number:	Zip Code:
Provider/Vendor Information	
CPT Codes/HCPC Codes:	Primary Diagnosis – ICD-10:
	Secondary Diagnosis – ICD-10:
Ordering Provider	Referred To Provider/Facility
Ordering Provider: Specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No If specialty _____	Referred to Provider: Specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No If specialty _____
Tax ID number:	Tax ID number:
NPI number:	NPI number:
Contact Person at referring provider's office:	Contact person at referred to provider's office:
Phone Number:	Phone Number:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Clinical Information Submitted for Determination	
Determination will be based on individual plan policy and clinical documentation submitted. Include all pertinent clinical documentation to support the request. Check all that apply.	
<input type="checkbox"/> Letter of Medical Necessity	<input type="checkbox"/> Diagnostic CDs
<input type="checkbox"/> Current Clinical Notes	<input type="checkbox"/> Colored Photos
<input type="checkbox"/> Labs	<input type="checkbox"/> Durable Medical Equipment Form
<input type="checkbox"/> Diagnostics Report	<input type="checkbox"/> Other
Signature	
Codes not requested at time of service may result in a denied claim.	
Requesting Person/Authorized Representative Signature:	Date Submitted: