PO Box 91110
Sioux Falls, SD 57109
(888) 278-6485
Fax: (605) 312-8219

Medical Prior Authorization Request

Please complete, sign and date this form.

Patient Information	
Member Name:	Member ID#:
Address:	City, State, Zip Code:
DOB:	Phone Number:

Provider/Vendor Information	
CPT Codes/HCPC Codes:	Inpatient: ☐ Outpatient: ☐
Date of Service:	Retro: ☐ YES ☐ NO
Primary Diagnosis – ICD-10:	Secondary Diagnosis – ICD-10:
Medication Requests (if applicable) Name: Dose:	Medication Directions:

Ordering Provider		**Referred To Provider/Facility**	
Ordering Provider Name: Specialty: No specialty ☐		Referred to Provider Name/Facility: Specialty: No specialty ☐	
Tax ID number:		Tax ID number:	
NPI number:		NPI number:	
Address:		Address:	
City, State, Zip Code:		City, State, Zip Code:	
Contact person at referring provider's office:		Contact person at referred to provider's office:	
Phone Number:	Fax Number:	Phone Number:	Fax Number:

Medical Prior Authorization Request - Page 2

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.	
☐ Letter of Medical Necessity	☐ Diagnostic CDs
☐ Current Clinical Notes	☐ Colored Photos
☐ Labs	☐ Durable Medical Equipment Form
☐ Diagnostics Report	☐ Other

Signature	
Codes not requested at time of service may result in a denied claim.	
Requesting Person/Authorized Representative Signature:	Date Submitted:

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