

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: | | Referred to Provider Name/Facility: | |
| Specialty: No specialty | | 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: |



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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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