Medical Prior Authorization Request

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6868
Fax: (605) 328-6813
sanfordhealthplan.com

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:

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:

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
- ☐ Current Clinical Notes
- ☐ Labs
- ☐ Diagnostics Report
- ☐ Diagnostic CDs
- ☐ Colored Photos
- ☐ Durable Medical Equipment Form
- ☐ Other

Signature

Codes not requested at time of service may result in a denied claim.

Requesting Person/Authorized Representative Signature:	Date Submitted: