Medical Prior Authorization Request

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

Please complete, sign and date this form. Effective **10/1/20** we will be requesting that prior authorization requests be sent via our portal on sanfordhealthplan.com. For instructions on how to request this access to the portal, please email providerrelations@sanfordhealth.org. For out-of-network prior-authorization requests, please fill out the Out of Network Prior Authorization Request Form instead. This is required in order to process a network exception request.

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: ____________________ 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:

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: