

PO Box 91110  
 Sioux Falls, SD 57109  
 (605) 328-6868  
 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: <input type="checkbox"/> Outpatient <input type="checkbox"/>
Date of Service:	Retro: <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Diagnosis – ICD-10:	Secondary Diagnosis – ICD-10:
Ordering Provider	Referred To Provider/Facility
Ordering Provider Name: _____	Referred to Provider Name/Facility: _____
Specialty: _____ <input type="checkbox"/> No specialty	Specialty: _____ <input type="checkbox"/> 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.	
<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: