Preauthorization Request Form

Please complete each section of this form. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: ____________________ Date of Birth: ____________________

Member ID Number: ____________________ Group Number: ____________________

ICD code(s), please list all that apply:____________________

CPT & HCPCS code(s), please list all that apply: ____________________

Place of Service ____________________

Admission/Procedure/Service Date: ____________________ Days/Units Requested: ____________________

Inpatient Services

- ☐ Behavioral Health
- ☐ Hospital Notification (first 5 days)
- ☐ Substance Abuse
- ☐ Other: ____________
- ☐ Gastric/Weight Loss Surgery
- ☐ Medical or Surgical*
- ☐ Swing Bed
- ☐ Hospice
- ☐ Skilled Nursing Facility
- ☐ Transplant, type ___________

* Maternity and newborn cases do not require preauthorization for inpatient stays less than 48 hours for vaginal delivery or less than 96 hours for cesarean section. Facilities must request extensions for hospital stays if the stay extends beyond the approved number of days.

Outpatient Services

- ☐ Ambulance/Transportation
- ☐ Breast Reconstruction/Reduction
- ☐ Dental
- ☐ Gastric/Weight Loss Surgery
- ☐ Home Health Care Services
- ☐ In-Network Benefits for an Out-of-Network Provider
- ☐ Occupational Therapy*
- ☐ Physical Therapy*
- ☐ Referral
- ☐ Spinal Disc Replacement
- ☐ TMS Therapy
- ☐ Anesthesia
- ☐ Chiropractic Services*
- ☐ Diagnostic Services
- ☐ Genetic/Pharmacogenetic Testing
- ☐ Hospice
- ☐ Infertility Diagnostic Services
- ☐ Orthotics & Prosthetics
- ☐ Plastic/Reconstructive Surgery
- ☐ Residential Treatment
- ☐ Spine Fusion
- ☐ Transplant Services, type: _____
- ☐ Applied Behavioral Analysis Therapy
- ☐ Clinical Trial
- ☐ Endovenous Ablation Therapy
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Pain Management Services
- ☐ Radiation Oncology
- ☐ Speech Therapy*
- ☐ Substance Abuse Treatment
- ☐ Other: ___________

* Only required if over their limited number of visits. Please specify the number of additional visits being requested: ________________

Durable Medical Equipment

- ☐ Bone/Joint Stimulator
- ☐ Hemodialysis Machine & Supplies
- ☐ Lift Systems
- ☐ Neuromuscular Stimulation Systems
- ☐ Oxygen & Supplies
- ☐ Speech Generating Devices & Accessories
- ☐ Wheelchair/Mobility Devices & Accessories
- ☐ Chest Vest
- ☐ Hyperbaric Oxygen
- ☐ Medical Bed/Mattress
- ☐ Nutrition, Enteral
- ☐ Passive Motion Exercise Device
- ☐ Transfer Systems
- ☐ Wound Therapy Devices & Supplies
- ☐ Continuous Glucose Monitor
- ☐ Infusion/Implantable Pump
- ☐ Nerve Stimulation Systems
- ☐ Nutrition, Parenteral
- ☐ Pneumatic Compression Device
- ☐ Ultraviolet Therapy
- ☐ Other: __________________

Provider Name: ____________________ Today's Date: ____________________

Person completing the form: ____________________ Office/Facility Name:____________________

Phone Number: (_____) ____________________ Fax Number: (_____) ____________________

(See Next Page)

Determination of medical necessity requires the submission of documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records:____

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Final determination will be faxed to the prescriber. Final determination will be mailed to the member.

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact DAKOTACARE Service Center at 605-334-4000 or toll-free at 1-800-658-5508. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to DAKOTACARE at **1-605-274-3279** or send a secure email to HealthServices@DAKOTACARE.com.