South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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Waiver Recipient Incontinence Prior Authorization Form

This form must be submitted with medical documentation as outlined in the DMEPOS manual.

Date:	Last date seen by provider:	
Date Service Limit was Exceeded:		
Recipient Information		
Medicaid ID:	DOB:	Sex (circle one): Male Female
Last Name:	First Name:	Level of Care:
Prescribing Provider Information		
NPI:	Taxonomy:	
Name:	Mailing Address:	
Phone:	Fax:	
Point of Contact Name:	Provider Signature:	
DME Provider Information		
NPI:	Taxonomy:	
Name:	Mailing Address:	
Phone:	Fax:	
Email:		
Supplies Information		
Description and Function of Supplies (including HCPCS, estimated number of units per month, and price per unit):		