Health KiCC

Medical Condition Verification

This form can be completed by any medical providers that have documentation of the below diagnosed condition(s) and could provide, upon request, such medical documentation.

Patient's Name:____ DOB: ______________

Parent's/Guardian's Name: ____

Address: ____Phone:__________________

Chronic medical condition(s) of patient. (As per ARSD 44:06, not all chronic medical conditions are covered by Health KiCC).

Child has been diagnosed with the below:

ICD 9 code: ____________ Name of diagnosis: ______________________________________

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ICD 9 code: ____________ Name of diagnosis: ______________________________________

ICD 9 code: ____________ Name of diagnosis: ______________________________________

Health KiCC also offers a 6 month diagnostic provision to identify if the child has a coverable condition. Once a diagnosis is made or at the end of the 6 month provision, Health KiCC will require documentation of a coverable condition for continued eligibility.

To request coverage under the 6 month provision, please list suspected ICD 9 code and diagnosis:

ICD 9 code: ____________ Name of diagnosis: ______________________________________

ICD 9 code: ____________ Name of diagnosis: ______________________________________

Provider Signature: ______________________________ Phone: _______________________

Printed Name:___________________________________ FAX: ________________________

Mail completed form to: Health KiCC
600 E. Capitol Ave.
Pierre, SD 57501

or

FAX to: Health KiCC
(605) 773-5683

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