



**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 10 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 diagnosis and ICD 10 code:*

*Suspected diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_*

*Suspected diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_*

Provider Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Printed Name: \_\_\_\_\_ FAX: \_\_\_\_\_

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

or FAX to: Health KiCC  
(866) 579-8246