Inpatient Authorization Request

Fax form to: **701-277-2971**

OR

Mail form to:
4510 13th Ave S
Attn: Utilization Management
Fargo ND 58121

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Instructions: Fax or mail the completed authorization request form with all supporting clinical documentation. All fields in this form are required unless otherwise indicated. If you have questions about this request, call BCBSND Utilization Management at 800-952-8462.

Member Information

Patient First Name

Patient Last Name

Patient Date of Birth (MM/DD/YYYY)

Member ID (including alpha-numeric prefix)

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other

Requesting Provider Information

Type:

☐ Provider
☐ Facility

Requesting Provider First Name

Requesting Provider Last Name

Fax Number

Specialty/Taxonomy Code

NPI

TIN (Optional)

Address Line 1

Address Line 2 (Optional)

City

State

Zip Code

Service Information

Service Type (Select One)

☐ Hospice ☐ Medical ☐ Rehabilitation ☐ Skilled Nursing Care ☐ Surgical ☐ Transplants
☐ Long Term Care ☐ Psychiatric ☐ Residential Psychiatric Treatment ☐ Substance Abuse ☐ Transitional Care

Place of Service (Select One)

☐ Comprehensive Inpatient Rehab Facility ☐ Inpatient Hospital ☐ Psychiatric Residential Treatment Center ☐ Skilled Nursing Facility
☐ Hospice ☐ Inpatient Psychiatric Facility ☐ Residential Substance Abuse Treatment Facility

Admission Date (MM/DD/YYYY)

Discharge Date (Optional)

Admission Type

☐ Elective ☐ Emergency ☐ Urgent

Quantity in Days

Diagnosis Code(s) (1 required, up to 11 more optional - use space on page 2 if more than 2 dx codes)

Code (ICD-10 ONLY)	Description

Procedure Code(s) (Optional - use space on page 2 if more than 2 proc codes)

Code (CPT/HCPCS)	Description	From Date	To Date	Qty	Qty Type (Days / Intl Units / Units)

Service Provider Information

Servicing Provider Name

Fax Number

NPI

TIN (Optional)

Address Line 1

Address Line 2 (Optional)

City

State

Zip Code

Completed by

Contact Phone Number

Today's Date

Member Information

Patient First Name

Patient Last Name

Patient Date of Birth (MM/DD/YYYY)

Member ID (including alpha-numeric prefix)

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other

Service Information Cont.

Diagnosis Code(s) (Use this space for up to 10 additional codes)

Code (ICD-10 ONLY)	Description

Procedure Code(s) (Use this space for up to 14 additional codes)

Code (CPT/HCPCS)	Description	From Date	To Date	Qty	Qty Type (Days / Intl Units / Units)