Outpatient Authorization Request

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

OR

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

ND

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)

☐ Applied Behavior Analysis Therapy
☐ Anesthesia
☐ Chemotherapy
☐ Diagnostic Lab
☐ Dental Accident
☐ Durable Medical Equipment Purchase
☐ Home Health Care
☐ Hospice
☐ Infertility
☐ In-vitro Fertilization
☐ Medical
☐ Occupational Therapy
☐ Oral Surgery
☐ Partial Hospitalization (Psychiatric)
☐ Pharmacy
☐ Physical Medicine
☐ Private Duty Nursing
☐ Prosthetic Device
☐ Respite Care
☐ Speech Therapy
☐ Substance Abuse
☐ Surgical
☐ Transplants

Place of Service (Select One)

☐ Ambulance (Air or Water)
☐ Ambulance (Land)
☐ Ambulatory Surgical Center
☐ Home
☐ Hospice
☐ Independent Laboratory
☐ Office
☐ Off-Campus Outpatient Hospital
☐ On-Campus Outpatient Hospital
☐ Partial Hospitalization

From Date (MM/DD/YYYY)

Level of Service

☐ Elective ☐ Urgent

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

Code (ICD-10 ONLY)	Description

Procedure Code(s) (1 required, up to 15 more 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

Type

☐ Clinic

☐ Facility

Servicing Provider First Name

Servicing Provider Last Name

Fax Number

NPI

TIN (Optional)

Address Line 1

Address Line 2

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)