Inpatient Authorization Request

Instructions: Please address all pages of this form. There may be a delay in response if this form is not completed in its entirety. All fields in this form are required unless otherwise indicated (optional / applicable). If you have questions about this request, call Blue Cross Blue Shield of North Dakota (BCBSND) Utilization Management at 800-952-8462.

Please send the completed authorization request form with all supporting clinical documentation by:

- Fax: 701-277-2971
- Mail: BCBSND
  Attn: Utilization Management
  4510 13th Ave S
  Fargo, ND 58121

Member Information	
Patient First Name	Patient Last Name
Patient Date of Birth	Member ID (including alpha-numeric prefix)
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

Service Information–Inpatient

Service Type (Select One)
If request is for outpatient services, please utilize Outpatient Authorization Request Form.

☐ Medical ☐ Surgical ☐ Transplant ☐ Psychiatric ☐ Substance Use

Place of Service (Select One)

☐ Inpatient Hospital
☐ Inpatient Hospice
☐ Swing Bed
☐ Acute Medical Inpatient Rehab Facility
☐ Inpatient Rehab Substance Use (3.7)
☐ Transitional Care Unit (TCU)
☐ Skilled Nursing Facility
☐ Residental Treatment Center
☐ Long Term Care Facility
☐ Inpatient Hospital Detox

Request Type (Select One)

☐ Initial (Complete Initial Service Information Section)
☐ Concurrent (Complete Concurrent Service Information Section)

Initial Service Information	
Start of Care Date	End of Care Date (If applicable)

Concurrent Service Information	
Start Care Date	Previously Approved Services
Start Date of Concurrent Care Request	CASE Number or REQ Number of Previous Request

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Diagnosis	
Diagnosis Code(s) 1 Required (Please use additional page if more ICD-10-CM codes are required)	
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description

Procedure Code	
Procedure Code(s) (CPT/HCPCS, **Required for Surgical Request.** Please use additional page if more CPT/HCPCS are requested.)	
Code (ICD-10-CM)	Description
Quantity Requested	Quantity Type (Days/Units)
Code (ICD-10-CM)	Description
Quantity Requested	Quantity Type (Days/Units)
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Code (ICD-10-CM)	Description
Quantity Requested	Quantity Type (Days/Units)

Provider Information		
Requesting Provider First Name	Requesting Provider Last Name	
Fax Number **(Required)**	Specialty/Taxonomy Code (Optional)	
TIN (Optional)	NPI	
Address Line 1		
Address Line 2 (Optional)		
City	State	Zip

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Servicing Provider/Servicing Facility Information		
Service Provider First and Last Name or Facility Name		
Phone Number **(Required)**	Fax Number **(Required)**	
NPI	TIN (Optional)	
Address		Suite
City	State	Zip

Completion Information	
Completed by Information	
Completed by Name **(Required)**	
Completed by Contact Phone Number **(Required)**	Today's Date
Contact for Additional Questions	
Additional Contact Name	Additional Contact Phone Number

Additional Codes If Needed	
Diagnosis Code(s) 1 Required	
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description

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Additional Codes If Needed

Procedure Code(s)

Code (ICD-10-CM)	Description
Quantity Requested	Quantity Type (Days/Units)
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