Outpatient 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–Outpatient

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

☐ Dental Accident	☐ Applied Behavior Analysis Therapy	☐ Oral Surgery
☐ Infertility	☐ Private Duty Nursing	☐ Anesthesia
☐ Prosthetic Device	☐ Partial Hospitalization (Psychiatric)	☐ Surgical
☐ Chemotherapy	☐ Partial Hospitalization (Substance Abuse)	☐ Home Health Care
☐ Transplants	☐ Durable Medical Equipment Rental	☐ Medical
☐ Pharmacy	☐ Durable Medical Equipment Purchase	☐ Diagnostic Lab
☐ Hospice	☐ 1915i (Medicaid Expansion Only)	☐ rTMS

Place of Service (Select One)

☐ Ambulance (Land)	☐ Ambulance (Air or Water)	☐ Hospice
☐ Office	☐ Ambulatory Surgical Center	☐ Partial Hospitalization
☐ Home	☐ Outpatient Hospital	☐ Outpatient Surgical

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)

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

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, **1 Required.** 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)
Code (ICD-10-CM)	Description
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Code (ICD-10-CM)	Description
Quantity Requested	Quantity Type (Days/Units)

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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

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)	
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description

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Additional Codes If Needed	
Diagnosis Code(s) *Continued*	
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Code (ICD-10-CM)	Description
Procedure Code(s)	
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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