

Out-of-State Non-Participating Health Care Provider Waiver Form



This form is for Blue Cross Blue Shield of North Dakota (BCBSND) Marketplace (Affordable Care Act) members who need non-urgent, nonemergency care from a provider outside of North Dakota who is non-participating with BCBSND.

Visit www.bcbsnd.com/find-a-doctor to see if you can get care from participating (non-urgent & nonemergency) providers to lower your cost.

Submit this waiver if:

- You are getting certain mental health or substance use services, such as intensive outpatient or partial hospitalization programs.
- You need specialized services, such as durable medical equipment, lab testing, radiology or wound grafting.
- You're seeking nonemergency services from a provider who is not part of the Blue Cross Blue Shield network.

Important things to know

- Even with an approved waiver, your costs will be based on what BCBSND considers reasonable for the service.
- Even with an approved waiver, your costs will be based on your BCBSND coverage as outlined in your enrolled plan. You are responsible for any charges above the plan allowance.
- If you do not get a waiver for services that require one, those costs may not be covered.
- Some services may require prior authorization. You can find out more about the process at www.bcbsnd.com/members/member-resources/prior-authorization.
- If you need help filing a claim, submitting an appeal, switching coverage or other services, visit www.bcbsnd.com/members/member-resources.

Instructions

1. Complete Sections A, B (if applicable), C and D of this form.
2. If you need assistance completing this form, please call the number on the back of your member ID card.
3. Submit completed forms by:
 - Fax: 701-277-2209
 - Mail: Blue Cross Blue Shield of North Dakota
PO Box 1570
Fargo, ND 58107-1570

* indicates a required field

Section A: Member Information					
First Name*		MI	Last Name*		
Date of Birth*			Member ID Number*		
Residential Street Address* Address Line 1*			Mailing Address (<i>If applicable</i>) Address Line 1 Address Line 2		
Address Line 2	City*	State*	ZIP Code*	City	State
ZIP Code					

Section B: Submitter Information

This is required if submitting on behalf of another individual.

First Name	MI	Last Name
Phone Number		
Address Line 1		
Address Line 2		
City	State	ZIP Code

Section C: Provider Information

First Name	Last Name	
Facility Name*	Facility NPI	
Facility Address Line 1		
Facility Address Line 2		
Facility City	Facility State	Facility ZIP Code

Section D: Service Information

Service Type

<input type="checkbox"/> Mental Health Intensive Outpatient Program	<input type="checkbox"/> Radiology Services
<input type="checkbox"/> Mental Health Partial Hospitalization	<input type="checkbox"/> Wound Grafting
<input type="checkbox"/> Substance Use Intensive Outpatient Program	<input type="checkbox"/> Durable Medical Equipment
<input type="checkbox"/> Substance Use Partial Hospitalization	<input type="checkbox"/> Other
<input type="checkbox"/> Laboratory Testing	

Other Service Specified (*if applicable from service above*)

Reason for Appointment*

Date of Service/Care*