Inpatient Authorization Request

Instructions: All fields in this form are required unless otherwise indicated (optional / applicable). If not completed in full, expect a delay in response.

Effective Jan. 1, 2025, Blue Cross Blue Shield of North Dakota (BCBSND) providers must use the Availity Essential Provider Portal. **Faxes and phone calls for preservice precertification requests will no longer be accepted** unless BCBSND gives approval due to system issues.

Providers outside of North Dakota without electronic access:

- fax this form along with clinical support records to 701-277-2971.
- for an urgent request, utilize the urgent fax line at 701-277-2138. When using the urgent fax line, you must write "urgent" on the case itself, so the Utilization Management (UM) team knows to prioritize.

"Urgent" definition: The absence of treatment could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function. "Urgent" can also mean in the opinion of the health care provider, with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is subject in this case.

Questions? Call BCBSND UM at 800-952-8462. If providers are unable to use Availity to submit photos or for member submitted requests, please mail request and/or photos to:

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)

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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	Authorization (AUTH-) 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, **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
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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): 1 Required

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
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