Inpatient Authorization Request

Instructions: 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
  4510 13th Ave S
  Attn: Utilization Management
  Fargo ND 58121

☐ Initial Review ☐ Continued Stay Review

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		

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

Facility Information		
Facility Name	Phone Number	
Fax Number	NPI	TIN (Optional)
Address Line 1	Address Line 2 (Optional)	
City	State	Zip
Completed by Information		
Completed by Name		
Completed by Contact Phone Number	Today's Date (MM/DD/YYYY)	
Contact for Additional Questions		
Additional Contact Name	Additional Contact Phone Number	

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Service Information

Service Type (Select One)

☐ Medical ☐ Surgical ☐ Transplant ☐ Psychiatric ☐ Substance Abuse

Place of Service (Select One)

☐ Inpatient Hospital ☐ Acute Medical Inpatient Rehab Facility ☐ Residential Treatment Center
☐ Inpatient Hospice ☐ Skilled Nursing Facility ☐ Transitional Care Unit ☐ Swingbed ☐ Inpatient Hospital Detox
☐ Inpatient Rehab Substance Use (level 3.7)

Request Type (Select One)

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

Initial Service Information

Admission Date (MM/DD/YYYY)	Discharge Date (If applicable)	Quantity in Days (Optional)

Diagnosis Code(s) (ICD-10-CM ONLY, 1 required, up to 12 more if applicable)

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

Initial Service Information

Procedure Code(s) (If applicable)

Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
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Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description

Concurrent Service Information

Admission Date (MM/DD/YYYY)	Previously Approved Date(s) of Service
CASE Number or REQ Number of Previous Request	Start Date of Concurrent Care Request (MM/DD/YYYY)
Quantity in Days Requested (Optional)	

Additional Diagnosis Code(s) since Initial Review (ICD-10-CM ONLY, If applicable)

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

Procedure Code(s) (If applicable)

Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description
Code (CPT/HCPCS)	Description