Outpatient Authorization Request

Instructions: Please address all 3 pages of this form in it's entirety and save it to your desktop prior to beginning. 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 Request ☐ Continued Care

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

Servicing Provider/Servicing Facility Information		
Service Provider First and Last Name or 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

29381058 • 11-19

Service Information

Service Type (Select One)

☐ Applied Behavior Analysis Therapy ☐ Dental Accident ☐ Infertility ☐ Oral Surgery ☐ Private Duty Nursing
☐ Anesthesia ☐ Partial Hospitalization (Psychiatric) ☐ Prosthetic Device ☐ Surgical ☐ Chemotherapy
☐ Home Health Care ☐ Partial Hospitalization (Substance Abuse) ☐ Respite Care ☐ Transplants
☐ Durable Medical Equipment Rental ☐ Durable Medical Equipment Purchase ☐ Medical ☐ Pharmacy
☐ Diagnostic Lab ☐ Hospice ☐ Occupational Therapy ☐ Physical Medicine ☐ Speech Therapy ☐ rTMS

Place of Service (Select One)

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

Request Type (Select One)

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

Initial Service Information

Start of Care Date (MM/DD/YYYY)	To Date (If applicable)

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

Initial Service Information

Procedure Code(s) (CPT/HCPCS, 1 Required, up to 14 more, if applicable)

Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)

Concurrent Service Information

Start Care Date (MM/DD/YYYY)	Previously Approved Services
CASE Number or REQ Number of Previous Request	Start Date of Concurrent Care Request (MM/DD/YYYY)

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

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

Procedure Code(s) (CPT/HCPCS, 1 Required, up to 5 more, if applicable)

Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)
Code (CPT/HCPCS)	Description	Quantity Requested	Quantity Type (Days/Units)