Inpatient Medical/Surgical Preauthorization

To request preauthorization for inpatient medical or surgical admission, please complete this form and attach any supporting clinical information requested. Completion of this form does not take the place of a referral for out-of-network services.

Requests can be mailed to:
Blue Cross Blue Shield of North Dakota
Attn: Health Network Innovation
4510 13th Ave. S., Fargo, ND 58121

Requests can be faxed to:
Health Network Innovation
701-277-2253

Member/Patient Information

Name: _____ Date of Birth: _____

Address: _____

Benefit Plan Number: _____

Clinical Information

Procedure Code(s) (CPT/ICD): _____

Procedure Description: _____

Diagnosis Code(s) (ICD-10): _____

Diagnosis Description: _____

Admission Date: _____ Discharge Date: _____

Emergency Room: Date: _____ Time: _____

Facility/Hospital Information

Facility/Hospital Name: _____

National Provider Identifier (NPI) Number: _____ BCBSND Provider Number: _____

Address: _____

Main Phone#: _____ UR/CM Phone#: _____

Provider/Physician Information

Provider/Physician Name: _____

National Provider Identifier (NPI) Number: _____ BCBSND Provider Number: _____

Address: _____

As the individual completing this form, please provide the following:

Name: _____ Phone: _____ Fax: _____

Case Management may contact you for discharge planning, dependent on diagnosis and length of stay.

Please call 1-800-952-8462 with a discharge date.

Preauthorization Information

BCBSND Use Only

DCN: _____ Next review: _____ Date: _____ Reviewer: _____