



Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

Fax to: (701) 277-2132
Mail to: BCBSND
Attn: Provider Service
4510 13th Ave S
Fargo, ND 58121

Provider Request for Contraceptive Coverage

Completion of this form, by the provider or clinic personnel, is required for contraceptive coverage consideration. Attach any additional information that should be considered with this request. Incomplete forms will be returned.

Prescriber Name: NPI: Specialty:

Clinic Name: Address: (Street, City, State, Zip Code)

Phone Number: Fax Number:

Patient Name: Date of Birth: (Last) (First) (MI) (MM/DD/YYYY)

Benefit Plan Number (Ex. YQA123456789):

Address: (Street, City, State, Zip Code)

Name/Type of Contraceptive:

Diagnosis/Description of Condition:

Additional Comments:

Completed by: Phone Number: Date: