MEDICAL PROCEDURE/DEVICE PRIOR AUTHORIZATION REQUEST

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 511 (01-2008)

Clear Fields

Send to: Medical Services Division
ND Department of Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544

PROVIDER INFORMATION

Billing Provider Name	Billing Provider Number	Telephone Number	Fax Number

Address	City	State	Zip Code

RECIPIENT INFORMATION

Last Name, First Name, Middle Initial	Medicaid ID Number	Gender	Date of Birth
		☐ Male ☐ Female	

See Medicaid Prior Authorization List for Medical Procedure Criteria (see website)

☐ Procedure Descriptor ☐ CPT/HCPCS Code

Explain nature of request including medical necessity/documentation supporting medical necessity:

* PLEASE ATTACH CARE PLAN IF APPLICABLE

Anticipated Date of Procedure

Signature of Requesting Provider (MD/DO)	Today's Date

REMARKS: **(STATE USE ONLY)** ☐ Approve ☐ Deny ☐ Pending	Start Date	End Date

Comments	☐ Criteria Reviewed ☐ More Information Needed

Signature of Reviewer

This form is available in a fillable format at the following website: www.nd.gov/eforms. We encourage you to complete the fillable format when submitting your medical procedure request for authorization. Please complete one form for each request.