# MEDICAL PROCEDURE/DEVICE PRIOR AUTHORIZATION REQUEST

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 511 (10-2008)

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 pages 171 to 174 of the General Information Providers Manual available at: www.nd.gov/dhs/services/medicalserv/medicaid/doc/gen-info-providers.pdf

☐ Procedure Descriptor ☐ CPT/HCPCS Code

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

* PLEASE ATTACH CARE PLAN IF APPLICABLE

| ICD-9 Code(s) |
|---|
| |
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| |
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| |

| 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<br>☐ 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.