REQUEST FOR PRIOR AUTHORIZATION FOR OUT-OF-STATE SERVICES

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 769 (6-2009)

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

NOTE: AN INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. *Approval of this request is not authorization for payment or approval of charge. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of services being enrolled in ND Medicaid. The provider of services must verify patient eligibility at the time the service is rendered. This authorization expires 60 days from approval, unless otherwise noted by Medicaid.*

MEDICAID ELIGIBILITY VERIFY LINE 1-800-428-4140

RECIPIENT Last Name	First	Middle Initial	Date Of Birth	Sex ☐ M ☐ F
Medicaid ID Number	Medicaid Eligibility Verified ☐ Yes ☐ No	Other Medical Insurance		Medicare Coverage ☐ Yes ☐ No
Attendant Requested ☐ Yes ☐ No	Medical Reason for Attendant		Name of Attendant	

Date(s) of Service	Quantity	Procedure Code-CPT/HCPC	Procedures/Services (Describe)
1.			
2.			
3.			

Diagnosis (ICD-9)

Reason for Out-Of-State Medical Treatment (**SEND ADDITIONAL INFORMATION WITH REQUEST** - see page 2 for the minimum information that must be sent.)

REFERRING Facility		Facility Contact Person	
Referring Physician		Telephone Number	Fax Number
Address	City	State	Zip Code
Referring Physician Signature (optional)		Physician's ND Medicaid Provider ID Number	

RENDERING Facility		Facility Contact Person	
Rendering Physician		Facility Fax Number	Telephone Number
Address	City	State	Zip Code
Services Provided in Hospital: ☐ Yes ☐ No	If Yes, Name of Hospital		
Hospital Contact Name		Telephone Number	

NORTH DAKOTA MEDICAL SERVICES USE ONLY:

Determination	**Travel Method**	**Attendant/Companion**	**Lodging**	**Meals**
Approved ☐	Car ☐ Bus ☐ Train ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pending ☐	Ambulance ☐ Stretcher Van ☐ W/C Van ☐		**Number of Days** _____	**Number of Days/Units** _____
Denied ☐	Air ☐ **Cost** _____			

Comments:

ND DHS Medical Consultant Signature	**Date**

PRIOR AUTHORIZATION REQUIREMENTS

- Out-of-state services at sites more than fifty statute miles from the North Dakota border must be prior authorized. (Canadian services are the excepition, and are not covered.)

- The recipient's Primary Care Physician must submit a written request to the ND Medicaid program for authorization for out-of-state services a minimum of two to three weeks before scheduling an appointment.

  Requests must include **all** of the following:

  1) Recipient's name, Medicaid ID number and date of birth
  2) Diagnosis
  3) Medical information supporting the need for out-of-state services
  4) A written second opinion from an appropriate in-state board certified specialist, following a current (within 3 months) examination, which substantiates the medical need for out-of-state care
  5) The physician and facility to which the patient is being referred
  6) Assurance that the service is not available in North Dakota

- The ND Medicaid office determines if the referral meets state requirements, and then approves or denies the request in writing. A copy of the determination is sent to the primary care physician, out-of-state provider(s), recipient and county social service office.

- Emergency out-of-state services are allowable at the in-state physician's discretion but are subject to Medicaid review and denial of claims. The transferring facility must notify ND Medicaid within 48 hours of the transfer. Documentation must include: destination and date of transfer, mode of transportation and discharge summary. If the trip was less than 50 miles, the facility must verify why air ambulance was used, rather than ground ambulance.

- Claims submitted out-of-state providers will not be paid without written prior authorization for services.

- Recipients of HMOs are not subject to prior authorization requirementsby ND Medicaid; however, they are subject to prior authorization requirements as established by the HMO.

- The recipient's County Social Service Office is responsible for assisting the recipient with arrangements for travel, lodging and meals.