PRIOR AUTHORIZATION REQUEST

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1115 (8-2009)

– Please refer to Pharmacy and Durable Medical Equipment Manuals for current prior authorization requirements.

ND Department of Human Services
Medical Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0261
701-328-4030; FAX 701-328-1544

Clear Fields

INSTRUCTIONS: PLEASE READ BACK FOR INSTRUCTIONS.

Patient's Name: Last	First	Middle	Date of Birth:	Client I.D. Number:
Patient's Address:				
Patient's Residence: ☐ NF/Swing Bed ☐ ICF/MR ☐ Basic Care ☐ Private Care				

I. TO BE COMPLETED BY PHYSICIAN

Item Prescribed:	Diagnosis & Prognosis **(Numeric Code)**:
Explanation of Medical Necessity, Duration of Need and Date of Visit:	

I certify that the above-prescribed durable medical equipment/supplies/medication is medically necessary for this patient's well being. In my opinion, this is reasonable and necessary in conformance with accepted standards of medical practice for the treatment of this condition. This has not been prescribed as a convenience to the patient.

Physician's Name: (Please Print)	Provider Number:	Physician's Signature:	Date:

II. TO BE COMPLETED BY PROVIDER (SUPPLIER)

Provider's Name:	Provider's Number:	Telephone Number:	
Provider's Street Address:	City:	State:	Zip Code:
Provider Signature:			Date:

PROPOSED MEDICAL EQUIPMENT OR SUPPLIES						STATE USE ONLY	
HCPC/NDC CODE	List: Item, make/model, units or days, quantity per case, and number of days supply hours/minutes of labor/evaluations. Continue on another page of form if necessary.	**DATE(S) OF SERVICE START/STOP**	**CUSTOMARY OR USUAL RETAIL**	**ACQUISITION COST**	**MOS. OF RENTAL/ QTY PRESCRIBED**	**MAXI REIM**	**APPR DENY**
	1)	Start					
Comments:		Stop					
	2)	Start					
Comments:		Stop					
	3)	Start					
Comments:		Stop					
	4)	Start					
Comments:		Stop					
	5)	Start					
Comments:		Stop					

I acknowledge that the approval of this request does not guarantee the eligibility of the recipient nor ensure payment for services. I understand that eligibility is established by the appropriate county social service board monthly and payment is contingent upon eligibility at the time the service is provided. I also understand that payment for such services may be denied unless prior approval is obtained.

REMARKS: (STATE USE ONLY)

DISTRIBUTION: **Original** - Submit to Medical Services for approval, a computer printed notice with the assigned request number and approval/denial will be returned. The number must be placed on the claim for payment.

INSTRUCTION FOR COMPLETION:

Section I - To be completed by the prescribing physician, provider name and physician signature are required. Justification for approval or denial of the medical equipment or supplies will be based upon this information. Along with the diagnosis, a comprehensive explanation of MEDICAL NECESSITY must confirm the prescription.

Section II - To be completed by the **provider (supplier)** of service. Complete name, address, telephone number and provider number should be entered. The proposed medical equipment/supplies/or medication to be described and listed separately. The description must be complete enough for the Department of Human Services to verify your customary or usual retail charge; acquisition cost must be indicated for all items (See DMEOPS Manual for rental specifics.) Upon completion, provider should **mail the original copy only** to: Medical Services, Department of Human Services, 600 East Boulevard Avenue, Bismarck, ND 58505-0261.

PRIOR AUTHORIZATION PROCESS:

1. The Department of Human Services will review, approve/deny, and key the request. A computer generated response with an assigned prior authorization number will be returned to the provider.
2. Upon approval, HCFA 1500 billers should enter the assigned prior approval number on the claim form before submitting to Medical Services for payment. The assigned prior approval number should **not** be submitted on pharmacy point-of-sale claims as the claims edit process locates and inserts the prior approval number electronically. Date(s) of Service must be indicated when submitting claims to this department for payment.

The Maximum Reimbursement listed is based on North Dakota Medical Services' fee. If other payor's/insurance is involved in the settlement of this claim, the Department of Human Services will abide by other payor's/insurance adjudication and accept other payor's/insurance allowable amount if different than the amount listed and adjudicate payment of deductible(s) and coinsurance amount(s).