SUBSTANCE USE DISORDER SERVICE AUTHORIZATION REQUEST

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 79 (6-2021)

Clear Fields

Please fax completed form to: 701-328-0371

Recipient Last Name			First Name	Middle Initial
Medicaid ID Number			Date of Birth	
Facility Name	NPI	Medicaid Provider Number	Psychiatrist	
Contact			Facility Fax Number	
Revenue Code (required)	CPT/HCPCS (required)	ICD Code	Telephone Number	

☐ ASAM Level 2.1	☐ ASAM Level 2.5	☐ ASAM Level 3.1
☐ ASAM Level 3.2	☐ ASAM Level 3.5	☐ ASAM Level 3.7

DIAGNOSIS

Axis I.	Axis III.
Axis II.	Axis IV.
GAF	
Locus/Calocus (Please complete Level of Care Chart on the following page and attach with your request)	
Reason for need for additional days and treatment plan:	

RECIPIENT CURRENT STATUS

Number of Days Already Attended	Additional Days/Level Requested	
Requested Beginning Date (required)	Requested Ending Date (required)	Estimated Length of Stay

MEDICAL SERIVCES USE ONLY:

Approved ☐	Number of Days	Begin	End	ASAM Level
Pending ☐	See below for comment			
Denied ☐	See below for comment			
Comments:				
Signature		Date		

An approval concerns only the medical necessity of these services and does not guarantee payment. Reimbursement for any service is contingent upon the eligibility of the patient at the time services are provided; any applicable third parties must be billed prior to billing Medicaid. The recipient may be responsible for any recipient liability before payment is made by this department. The approved days are inclusive of all other payers. Providers are responsible for maintaining current Medicaid enrollment. Failure to do so will result in non-payment of services. Effective November 1, 2008, discharge documentation is required by North Dakota Medicaid. Eligibility for dates of service may be verified by calling 1-877-328-7098 or 701-328-7098.