COORDINATED SERVICES PROGRAM (CSP) REFERRAL

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 231 (Rev. 12-2018)

Clear Fields

NOTE:THIS FORM IS FOR A CSP REFERRAL ONLY! AN INCORRECT FORM WILL DELAY THE AUTHORIZATION PROCESS.
FOR AN OUT OF STATE REFERRAL REQUEST USE SFN 769.
FOR A PRIMARY CARE CASE MANAGEMENT (PCCM) REFERRAL USE SFN 708.
(both forms are available on www.nd.gov/eforms)

Date of Referral	Member Name (Last, First)

Member Medicaid ID Number	Member Date of Birth

Referring Provider Name	Referring Provider NPI

Referral To (provider last name, first name)	Referred To Provider NPI
Referral Begin Date	Referral End Date

Please mail to:		**Fax to:**
Surveillance and Utilization Review Medical Services 600 E Boulevard; Dept 325 Bismarck ND 58505-0250	**OR**	(701) 328-1544

- Fill out completely for each CSP member referral.
- Referral must be provider specific.
- If an ongoing referral, indicate "12/31/1999" in the Referral End Date box.
- Only one open referral per provider specialty.
- This form may be copied.