MEDICAL PROCEDURE/DEVICE/DRUG SERVICE AUTHORIZATION REQUEST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 511 (8-2024)

Clear Fields

Procedure/Device Request
Billing Provider Name and NPI - name of the clinic, group, or sole proprietor and associated NPI that will be listed in Box 33 (a) and (b) of the CMS 1500 or electronic equivalent (not the individual rendering provider).

Billing Facility Name and NPI - name of the facility, hospital, or ambulatory surgery center and associated NPI that will be billing for the technical or facility portion of the surgical procedure (where the surgery will be performed).

Two authorization numbers will be assigned (when applicable), incomplete requests will be returned.

Provider Administered Drug Request
Billing Provider Name and NPI - name of the clinic, group, or sole proprietor and associated NPI that will be listed in Box 33 (a) and (b) of the CMS 1500 or electronic equivalent (not the individual rendering provider).

Modifiers
CPT and HCPCS codes must be requested exactly how they will appear on the claim. All applicable modifiers must be present on the service authorization request. Failure to do so will result in a denial of the claim.

RECIPIENT INFORMATION

Recipient Last Name, First Name, Middle Initial	Recipient Medicaid ID Number	Date of Birth

ICD-10 CM CODES (required)

1)	2)	3)	4)	5)
6)	7)	8)	9)	10)

REQUESTING PROVIDER CONTACT

Contact Person Name	Telephone Number	Fax Number	Today's Date

PROCEDURE/DEVICE REQUEST

Billing Provider Name (see instructions above)	Billing Provider NPI	Requested Date of Procedure
Billing Facility Name		Billing Facility NPI

CPT/HCPCS Code and Applicable Modifier

1) Code	Mod	2) Code	Mod	3) Code	Mod	4) Code	Mod

Nature of Request (attach most recent documentation including progress notes and pertinent diagnostic study reports)

PROVIDER ADMINISTERED DRUG REQUEST (if applicable)

Billing Provider Name	Billing Provider NPI	Requested Date of Administration
Billing Facility Name		Billing Facility NPI

HCPCS Code	Dosage	Frequency

Nature of Request (attach most recent documentation including progress notes and pertinent diagnostic study reports)

REMARKS (state use only)

☐ Approve	Start Date	End Date	Clinical SA Number	Facility SA Number
☐ Deny	Reason			
☐ Pending	Reason			

Comments

Signature of Reviewer

Prior authorization does not guarantee payment for the services; payment is contingent upon passing all edits contained within the claims payment process, the recipients continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the services.

Send to:

Medical Services Division
Department of Health and Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544