

NDHCRI Request for Preadmission/Preprocedure Authorization

Mail to: North Dakota Health Care Review, Inc.
800 31st Ave. S.W.
Minot, ND 58701

Phone: (800) 472-2902
(701) 852-4231
Fax: (701) 838-6009

Patient Name _____ ND MA# _____

Address _____ Birth Date _____ Sex: M or F

City/State/Zip _____

Form completed by _____ Clinic/Hosp. Phone # _____

Surgical Procedure Data

Provider/Hospital Name _____ Provider # _____

Surgical MD _____ State License/UPIN # _____

Address _____

Setting to be performed: (Check one) Admit Date: ____/____/____

____ Acute Inpatient Hospital setting

____ Hospital Outpatient Department

____ Ambulatory Surgical Center

Surgery Date: ____/____/____

Procedure to be performed: _____

Or

Admitting Diagnoses: _____

Patient Complaints/Clinical Summary:

Support Documentation: Please send pertinent clinic notes from the Primary Care Physician (PCP) and surgeon to support the medical necessity of the procedure to be performed. Without this supporting documentation, NDHCRI will be unable to perform the preauthorization.

The absence of this information will delay the process and will require NDHCRI to return the request to the clinic/provider to obtain further information.

NOTE: This information is to be mailed or faxed in at least 2 WEEKS PRIOR to the date of surgery.