Quality Health Associates of North Dakota
Request for Preadmission/Preprocedure Authorization

Mail to: Quality Health Associates of North Dakota
41 36th Avenue NW
Minot, ND 58703

Phone: (701) 989-6220
Fax: (701) 838-6009

Patient Name _____ ND MA#_____

Address _____ Birth Date _____ Sex: M or F

City/State/Zip _____

Form completed by _____ Contact Phone # _____

Contact Fax # _____

Surgical Procedure Data

Facility Name _____ Provider # _____

Surgical MD _____ NPI #_____

Physician Address _____

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

____ Acute Inpatient Hospital

____ Hospital Outpatient Department Proposed Surgery Date: ____/____/____

____ Ambulatory Surgical Center

____ Acute Long Term Care Facility

____ Clinic

Procedure to be performed (including CPT or ICD-9 procedure code(s)): _____

OR

Admitting Diagnoses (if Mandan/Fargo ALTC admission): _____

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, QHA will be unable to perform the preauthorization.

The absence of this information will delay the process and will require QHA 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.