SANFORD HEALTH PLAN

NORTH DAKOTA MEDICAID EXPANSION

Medical/Pharmacy Services Lock-In (CSP) Program
Request for Review of Medical or Prescription Drug Use

Sanford Health Plan requires certain information for individuals who may qualify for the Lock-In/Coordinated Services Program (CSP), which restricts a member to one primary care provider and one pharmacy to aid Members in accessing and utilizing medical services in the most appropriate setting. The information provided will remain confidential.

Please provide the information below and submit to Sanford Health Plan by secure electronic transmission.
If unable to submit electronically via secure means, please fax this form to (605) 328-6813.

Instructions: Type or print clearly.

SECTION I — MEMBER INFORMATION

Name — Member (Last, First, Middle Initial)

Member Address – Including City, State, and Zip Code

Social Security Number	ND Medicaid ID Number (if known)
Date of Birth	Sanford Health Plan Member ID Number (if known)
Currently active in a Coordinated Service Program (CSP)? □ Yes □ No □ Unknown □ Other (explain):_____	If YES, date active in CSP (if known)

SECTION II(A) — REASONS FOR REQUEST TO PLACE OR REVIEW PLACEMENT OF MEMBER IN COORDINATED SERVICE PROGRAM (CSP)

Reason (Check the appropriate reason for the referral. **Please provide details in Section II(B) for the reason(s) indicated below.**)

- ☐ Member utilizes / is suspected of utilizing multiple pharmacies to obtain prescriptions.
- ☐ Member utilizes / is suspected of utilizing multiple prescribers to obtain prescriptions.
- ☐ Member visits emergency room multiple times, possibly for the purpose of obtaining prescriptions.
- ☐ Member has / is suspected of having multiple prescriptions of the same or similar type of controlled substance.
- ☐ Member was previously enrolled in traditional Medicaid FFS lock-in (CSP) program
- ☐ NDDHS has received information regarding investigation of this Member by a government agency (law enforcement or other gov't funded program)
- ☐ Other _____

SECTION II(B) — DETAILS FOR REASON(S) FOR REQUEST TO PLACE OR REVIEW PLACEMENT OF MEMBER IN COORDINATED SERVICE PROGRAM (CSP)

Details related to reason(s) requesting to place or review placement in coordinated service program (CSP), as indicated in Section II(A). (Please attach additional pages as needed)

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SECTION III — REQUESTER INFORMATION

Requested by:

☐ Health care provider. ☐ Pharmacy. ☐ Caseworker/County Eligibility Worker.

☐ Emergency room department. ☐ Other: _____

☐ NDDHS (indicated NDDHS contact name/department):_____ __

Name — Requester	Date Submitting This Request
Facility Name — Requester Organization	National Provider Identifier — Requester (Optional)
Telephone Number — Requester	Fax Number — Requester
E-mail — Requestor	**Requestor's Signature**