Coordinated Services Program (CSP) Appeal Form

Please attach any additional information that should be considered with this request, and fill out the form completely.

Return this form and the authorized representative form (if you have an authorized representative) by:

- Mail: BCBSND
  PO Box 1570
  Fargo, ND 58107-1570
- Fax: 701-277-2209

Please keep copies of this form and all documents and correspondence related to this program.

Member Information		
Member Name		
Phone	Address	
City	State	Zip
Member ID Number	Pharmacy ID Number	Date of Birth (mm/dd/yyyy)

Contact Information of Person Filing Request for CSP Appeal		
Check one: ☐ Member ☐ Authorized Representative If the person filing the request for CSP Appeal is someone other than the Member, please submit the appropriate Authorized Representative Form with this request. The form is located at medicaid.bcsbnd.com in the resources section.		
Name of Person Completing This Form		
Address		
City	State	ZIP
Daytime Phone Number		

CSP Placement Appeal Reasons

Briefly discuss why you disagree with the decision to be placed in the Coordinated Services Program (attach additional information if available)

Signature	Date (mm/dd/yyyy)

The CSP is administered by BCBSND in collaboration with the ND DHS per the requirements of 42 C.F.R.§431.54.