



**HEALTH INSURANCE COST-EFFECTIVENESS REVIEW**  
 ND DEPARTMENT OF HUMAN SERVICES  
 MEDICAL SERVICES DIVISION  
 SFN 817 (Rev. 01-2002)

**Send To:** Medical Services Division  
 ND Department of Human Services  
 600 E Boulevard Ave Dept 325  
 Bismarck ND 58505

**CASE INFORMATION**

Case Name:	Case Number:	County:
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**INSURANCE INFORMATION**

Insurance Name:			
Insurance Address:	City:	State:	Zip Code:
Policy Number:	Policy Holder Name:	Type of Policy:	
Employer Name:			Employer Telephone Number:
Employer Address:	City:	State:	Zip Code:
Premium:	Date Due:	Is Amount:	
Deductible:	Co-Insurance:		
Insurance Coverage: (Check All That Apply)			
Exclusions or Limits on Coverage:			

**WHO IS COVERED**

Persons Covered by Insurance	DOB/Age	Medicaid Eligible	Recipient Liability

Describe any Known Illness or Medical Condition for Medicaid Eligible Individuals Covered by Insurance:

**ADDITIONAL COMMENTS**

**PLEASE ATTACH AVAILABLE INSURANCE PAYMENT HISTORY (EOB's etc.) and HEALTH INFORMATION FROM THE PAST 12 MONTHS.**

Eligibility Worker:	Date Submitted:
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**DISTRIBUTION: WHITE - Medical Services**

**CANARY - CSSB**