MEDICAID PAYMENT ALERT

TO: CLAIMS AUDITOR
MEDICAID CLAIMS PROCESSING
MEDICAL SERVICES DIVISION
600 E BOULEVARD DEPT 325
BISMARCK, ND 58505-0250

FAX: 701-328-0378

FROM: _____

_____

_____

_____

PROVIDER NUMBER: _____

NPI: _____

NAME	MEDICAID ID NUMBER	SOCIAL SECURITY NUMBER	BIRTH DATE	ADMISSION DATE	ORIGINAL LOC DATE	RETRO LOC DATE *	STATE OFFICE USE

SIGNATURE:

DATE OF REPORT:

Note: This form must be submitted on all new Medicaid recipients and recipients who apply for Medicaid after review is completed by DDM Ascend and Medicaid ID is obtained. All fields must be completed or form will be returned.

* If date is entered documentation must be attached.