REQUEST FOR EXTRA TIME
INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 64 (5-2021)

Clear Fields

Provider Name/Dental Office			Date	
Address	City		State	Zip Code
Recipient Name	Medicaid ID			

ND Medicaid has received a service authorization requesting the payment for extra time for the above named recipient. Prior to processing this request, The Department will need to verify that extra time is required. The form must be signed by the DD provider, guardian or caregiver acknowledging that the recipient requires extra time.

Submit this form along with the service authorization to:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave; Dept 325
Bismarck ND 58505-0250

We appreciate your continued participation in the North Dakota Medicaid program.

If you have any questions, please call Provider Relations at (701) 328-7098 or (877) 328-7098.

☐ Recipient needs extra time ☐ Recipient does not require extra time

Name (Printed Name)	Name (Signature Required)