ASSIGNMENT OF BENEFITS

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 560 (Rev. 01-2002)

Clear Fields

Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect participation in this program.

Name:
Case Number:
Social Security Number:

ASSIGNMENT OF BENEFITS

I, the undersigned, as qualified for Medical Assistance for myself and/or my dependents under the North Dakota Department of Human Services, understand that, to the extent of such assistance provided, state law gives the Department all of my recovery rights to benefits under the terms of any private health care coverage, medical payments programs, or any other third party liability resources which I have or may have.

Therefore, in consideration of any such assistance received by myself, my spouse and any of my children, including any children not yet born, I, the undersigned, hereby assign and transfer to the Medicaid Agency any and all rights to benefits occurring to me, my spouse and any of my children, including any children not yet born, under any private health care coverage, medical payments programs or any other third party liability resources which I have or may have, to the extent of the cost of care paid under the program.

I hereby authorize payment to the Medicaid Agency of any such benefits to which I may become entitled to the extent of the cost of care paid under the program. A copy of this assignment shall be valid as the original.

Signature:	Date:	
Street Address:	Telephone Number:	
City:	State:	Zip Code: