ASSIGNMENT OF BENEFITS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 560 (1-2023)

Clear Fields

Name
Case Number
* Social Security Number

* 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.

ASSIGNMENT OF BENEFITS

I, the undersigned, has qualified for Medical Assistance for myself and/or my dependents under the Department of Health and 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

Return your signed and dated form to your local human service zone office
OR
Submit by mail to:
Department Of Health and Human Services
Customer Support Center
PO Box 5562
Bismarck ND, 58506
OR FAX: (701)-328-1006
OR Email: **applyforhelp@nd.gov**

For questions call Customer Support Center at: 1-866-614-6005

Human service zone office locations can be found here: https://www.hhs.nd.gov/human-service/zones