MEDICAID QUESTIONNAIRE AND ASSIGNMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 566 (9-2015)

Clear Fields

NOTICE: Medicaid has made or may make payment for services provided to you. The following information is necessary to determine if other sources of payment are available for recovery of Medicaid funds. It is the applicant or eligible client's responsibility to take reasonable measures to identify and report resources and assist the Department in obtaining information and payment from these resources. To assure continued benefits, please return this form within 30 days of receipt.

All questions must be answered in the applicable sections and your signature must be entered on the reverse side where indicated.

SECTION I - CLIENT INFORMATION

Full Name			Telephone Number
Mailing Address (Street)	City	State	ZIP Code
Medicaid Case Number	Medicaid ID Number		
Other Family Members Injured			
Date of Accident	Time of Accident	Injuries Received	

Where did accident occur?
☐ Work ☐ Auto ☐ Home ☐ School ☐ Other _____

Are you receiving insurance or other benefits from someone else because of the accident or injury? ☐ Yes ☐ No

If yes, list name and address of contact person: _____

Have you, or are you, considering taking legal action against another party because of the accident or injury? ☐ Yes ☐ No

If yes, list name and address of attorney: _____

Was medical treatment sought due to the accident? ☐ Yes ☐ No	If yes, where did treatment occur? _____

Address/Location of Accident

Attorney Name (if applicable)	Attorney Telephone Number (if applicable)

SECTION II - IF VEHICLE ACCIDENT

A. Were you
☐ Driver ☐ Passenger ☐ Pedestrian

Name of Policyholder	Name of Insurance Company		
Policy Number	Claim Number		
Address to Send Claim			Telephone Number

B. Type of vehicle which struck you or the car in which you were riding:
☐ Auto ☐ Motorcycle ☐ Other _____

Name of Driver			Telephone Number
Address	City	State	ZIP Code
Owner of Vehicle			Telephone Number
Address	City	State	ZIP Code

SECTION II - IF VEHICLE ACCIDENT (CONT)

Name of Insurance Company		Telephone Number
Policy Number	Claim Number	
Do you or other family member or other living in household own a vehicle? ☐ Yes ☐ No		
Name of Insurance Company		Telephone Number
Policy Number	Claim Number	
Name of Insured		

SECTION III - OTHER TYPE OF ACCIDENT

Location		
Business, Homeowner or Other Name		
Name of Insurance Company		
Policy Number	Claim Number	

SECTION IV - WORKERS COMPENSATION

Name of Employer		Company Telephone Number
Department of Work		
Employee Number	Type of Injury	Date of Injury
Have you filed a claim for Workers Compensation? ☐ Yes ☐ No		
If yes, are you presently receiving benefits? ☐ Yes ☐ No		
If not receiving benefits, is your claim pending? ☐ Yes ☐ No		
Do you have an attorney? ☐ Yes ☐ No		
Name of Attorney		Telephone Number
Address	City	State / ZIP Code
What are your specific injuries related to this accident?		
Workers Compensation Claim Number		
Are you currently appealing the Worker's Compensation Decision? ☐ Yes ☐ No		

MEDICAID ASSIGNMENT OF BENEFITS

In consideration of Medical Assistance rendered by the North Dakota Medicaid Program, I hereby assign to the North Dakota Department of Human Services all rights to benefits otherwise payable to me for hospital, surgical or medical services rendered to myself or any of my dependents, and I authorize payment of said benefits directly to the North Dakota Department of Human Services, the state Medicaid agency. I fully understand this assignment and acknowledge that I have an obligation to reimburse the state of North Dakota for hospital and medical expenses paid on my behalf or on the behalf of my dependents, in the event I have a right of recovery under any policy of insurance, or against any person who may be liable for the medical expenses.

Printed Name	
Signature	Date