REQUEST FOR BENEFICIARY SERVICE COVERAGE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 814 (Rev. 01-2020)

Name	Telephone Number	Date of Request	
Address	City	State	ZIP Code

1. Describe the service or benefit that you would like North Dakota Medicaid to cover.

2. Have you previously asked for the service to be covered? If so, what was the reason you were told that it could not be covered?

3. Do you know of other Medicaid beneficiaries who would likely benefit from this same service if it were covered by North Dakota Medicaid?

4. If you are a parent answering this on behalf of your child, please provide the age of your child:

All requests will remain confidential, private, and will never impact enrollment in the program.

Please return this assessment to:

Medical Services - DHSMED@ND.GOV
ND Department of Human Services
600 E. Boulevard Ave, Dept. 325
Bismarck, ND 58505-0250
Fax: (701) 328-1544