HEALTH INSURANCE COST-EFFECTIVE REVIEW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 817 (1-2023)

Clear Fields

Send To: Medical Services Division
Department of Health and Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505

CASE INFORMATION

Case Name	Case Number	County

INSURANCE INFORMATION

Insurance Name			
Insurance Address	City	State	ZIP Code
Policy Holder Name	Policy Number	Type of Policy ☐ Individual ☐ Employer Group ☐ Other Group	
Employer Name			Employer Telephone Number
Employer Address	City	State	ZIP Code
Premium	Due Date	Is Amount ☐ Weekly ☐ Bi-Weekly ☐ Quarterly ☐ Monthly	
Deductible	Co-Insurance		

Insurance Coverage (check all that apply)

☐ Doctor Visits	☐ Specific Illness	☐ Dental	☐ Prescriptions
☐ Nursing Home/Home Health	☐ Inpatient Hospital	☐ Medicare Extended	☐ Vision
☐ Lab/X-rays	☐ Major Medical	☐ Outpatient Hospital	☐ Other _____

Exclusions or Limits on Coverage

WHO IS COVERED

Persons Covered by Insurance	DOB/Age	Medicaid Eligible	Recipient Liability

Describe any Known Illness or Medical Condition for Medicaid Eligible Individuals Covered by Insurance

ADDITIONAL COMMENTS

ATTACH AVAILABLE INSURANCE PAYMENT HISTORY (EOB's etc.) and HEALTH INFORMATION FROM THE PAST 12 MONTHS.

Eligibility Worker	Date