HEALTH INSURANCE COST-EFFECTIVE REVIEW

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 817 (Rev. 01-2002)

Clear Fields

Send To: Medical Services Division
ND Department of 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 Number:	Policy Holder Name:	Type of Policy: ☐ Employer Group ☐ Individual ☐ Other Group	
Employer Name:		Employer Telephone Number:	
Employer Address:	City:	State:	Zip Code:
Premium:	Date Due:	Is Amount: ☐ Weekly ☐ Bi-Weekly ☐ Quarterly ☐ Monthly	
Deductible:	Co-Insurance:		

Insurance Coverage: (Check All That Apply)

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

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

Eligibility Worker:	Date Submitted:

DISTRIBUTION: **WHITE** - Medical Services **CANARY** - CSSB