MEDICAID PAYMENT ALERT - RESIDENTIAL CHILD CARE FACILITY (RCCF) / BASIC CARE FACILITY (BC)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 950 (9-2017)

Clear Fields

NOTE: This form must be submitted for all Medicaid members upon admission and/or readmission to a residential child care facility or basic care facility.

All fields must be completed or form will be returned.

PROVIDER INFORMATION

Facility Provider Number	NPI Number		
Facility Name	Contact Name		
Address	City	State	Zip Code
Contact Telephone Number	Contact Fax Number		

PROVIDER TYPE

☐ RCCF ☐ Basic Care

MEMBER INFORMATION

Name	Medicaid ID Number	Social Security Number	Date of Birth

PAYMENT ALERT INFORMATION

Admission Date	Readmission Date	Discharge Date *

* Providers must submit an updated Payment Alert when member is discharged from facility.

SIGNATURE

Signature	Date

The completed form must include a coversheet and faxed to (701) 328-0378

Due to confidentiality a completed form cannot be emailed to the Department

The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.