MEDICAID PAYMENT ALERT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 991 (8-2017)

Clear Fields

NOTE: This form must be submitted for all Medicaid members once a Medicaid ID is obtained, Level of Care (LOC) and/or Certification of Need (CON) is completed.

All fields must be completed or form will be returned.

PROVIDER INFORMATION

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

PROVIDER TYPE

☐ Acute Psychiatric ☐ PRTF ☐ IMD ☐ NF ☐ Swingbed

MEMBER INFORMATION

Name	Medicaid ID Number	Social Security Number	Date of Birth

PAYMENT ALERT INFORMATION

Admission Date	Original LOC or CON Date[1]	Retro LOC Date [2]	Discharge Date [3]

1 LOC=Level of Care, CON = Certificate of Need.
* Date entered should be the original LOC/CON date or the effective date of the most recent LOC/CON determination.
2 NF providers- if a date is entered in this field, NF providers must attach documentation. If not applicable, must enter N/A.
3 Swingbed providers must submit an updated Payment Alert when member is discharged from swingbed unit.

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.