REQUEST FOR SERVICES

NORTH DAKOTA DEPARTMENT OF HEALTH
SPECIAL HEALTH SERVICES (SHS)
SFN 1103 (10-2020)

Concerns regarding the application process or authorized services should be sent in writing to Special Health Services (SHS), North Dakota Department of Health, 600 E Boulevard Ave Dept 301, Bismarck, ND 58505-0200. Questions can be directed to SHS at 800.755.2714.

INSTRUCTIONS: Complete Section I and II if applicant is requesting a diagnostic examination only. If applicant needs financial assistance to start treatment, complete Section I and III to apply for services.

SECTION I. CLIENT INFORMATION

Name of Client	Social Security Number	Birth Date

SECTION II. DIAGNOSTIC TESTING AND EVALUATION APPLICATION

Specialist's Name to Request Diagnostic Services	Clinic Name		City
Describe Disability or Medical Problem			
Signature of Applicant	Date	Relationship	County

I understand that this is a request for diagnostic services only. If financial assistance is needed for treatment, Section III "Treatment Application" needs to be completed.

Signature of SHS Claims/Eligibility Administrator	Date

Disposition of Diagnostic Application (To Be Completed by State Office Only)

Diagnostic Application ☐ Approved ☐ Not Approved Because:	Effective Date
Signature of Medical Director/SHS Designee	Date

SECTION III. TREATMENT SERVICES APPLICATION

Assistance Requested for the Following Medical Condition(s)

I understand that Special Health Services (SHS) does not cover sums for which there is any type of insurance coverage; or for which there is a recovery of money relative to the physical or medical condition for which application is made and that SHS is to be reimbursed for any payment for which recovery of funds is secured. I agree that the payment of any sums by SHS for services which are covered by insurance or may be recoverable because of the legal liability of a third party, will result in an automatic assignment to SHS of any claim for such sums and I hereby agree to such an assignment. I have read this application or had it read to me, and certify that all statements herein are true to the best of my knowledge.

Signature of Applicant	Date	Relationship	County
Signature of SHS Claims/Eligibility Administrator			Date

Disposition of Treatment Application (To Be Completed by State Office Only)

Treatment Application ☐ Approved ☐ Not Approved Because:	Effective Date
Signature of Medical Director/SHS Designee	Date

No one shall be denied participation in or benefits of SHS or be subject to discrimination on the basis of race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage or public assistance. Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. It may also be used for the purposes of Medicaid reimbursement and reporting requirements of caseload numbers. Failure to disclose the social security number will not affect participation in this program.

DISTRIBUTION: The original copy of this form will remain in SHS and be distributed to necessary providers.