# 1915(I) REQUEST FOR SERVICE PROVIDER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1505 (6-2021)

Clear Form

**SUBMIT FORM VIA EMAIL TO:**
Selected Service Provider

This form is utilized by the care coordinator to request service providers as identified by the member. The information contained in this request is identified in the plan of care. Please attach the 1915(i) Comprehensive Person-Centered Plan of Care to this form and send to each provider identified in the plan of care. Submit one Request for Service Provider form for each service requested.

The selected service provider must respond within two (2) business days to the care coordinator with an acceptance or denial of this request.

## Client Information

| Client Name (Last, First, MI) | ND Medicaid ID Number |
|---|---|
| | |

## Service Requested

- ☐ Care Coordination
- ☐ Benefits Planning Services
- ☐ Family Peer Support
- ☐ Housing Supports (Pre-tenancy)
- ☐ Housing Support (Tenancy)
- ☐ Non-Medical Transportation
- ☐ Peer Support
- ☐ Pre-Vocational Training
- ☐ Respite Care
- ☐ Supported Education
- ☐ Supported Employment
- ☐ Training and Supports for Unpaid Caregivers*
  - ☐ H0039 code/15 minutes and/or ☐ T2025 code/per service

*If both 15 minute and per service are selected, please identify units/dollar amount, frequency, and duration for each

| Units or Dollar Amount Requested: | Frequency Limit Requested: | Duration Limit Requested: |
|---|---|---|
| | | |

## Care Coordinator

| Care Coordinator | Telephone Number | Email Address |
|---|---|---|
| | | |

| Signature | Date Request Sent |
|---|---|
| | |

## Service Provider

1st Choice of Provider

| Provider | |
|---|---|
| Telephone Number | Email Address |
| ☐ I accept this request. ☐ I deny this request. | |
| Reason(s) for Denial | |
| Signature of Provider | Date |

2nd Choice of Provider

| Provider | |
|---|---|
| Telephone Number | Email Address |
| ☐ I accept this request. ☐ I deny this request. | |
| Reason(s) for Denial | |
| Signature of Provider | Date |

3rd Choice of Provider

| Provider | |
|---|---|
| Telephone Number | Email Address |
| ☐ I accept this request. ☐ I deny this request. | |
| Reason(s) for Denial | |
| Signature of Provider | Date |

**Return form to care coordinator via email.**