REQUEST FOR EXTRA TIME
INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 64 (2-2010)

Clear Fields

Name	Date
Address	
City State Zip	Recipient

We have received a claim requesting the payment for extra time for the above named recipient. Prior to processing this claim, we need to verify that extra time is required. You need to check with the recipient or DD provider who brought the recipient to your office and have them sign the bottom of this form acknowledging the fact the recipient requires extra time.

We are returning your claim and request you return the claim and completed form to the address below as soon as possible.

Medical Service
North Dakota Department of Human Services
600 E Boulevard Ave; Dept 325
Bismarck ND 58505-0250

We appreciate your continued participation in the North Dakota Medicaid Program.

If you have any questions, please call Provider Relations at (701) 328-4043.

☐ Recipient needs extra time ☐ Recipient does not require extra time

Name of DD Provider	Signature of authorized individual from DD Provider