NORTH DAKOTA MEDICAID PROVIDER APPEAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 168 (5-2023)

Clear Fields

Provider Name			Provider Number
Entity Handling the Appeal (if different than Provider)			
Appeal Contact Person			Telephone Number
Mailing Address for Appeal Correspondence	City	State	ZIP Code
Medicaid Recipient Name			Medicaid Recipient Number
Date(s) of Service	Date of Remittance Advice or Notice of Recoupment or Adjustment		
Reason for appealing denial, reduction, recoupment, or adjustment of payment from the North Dakota Medicaid program, and a statement of each disputed item with the reason or basis for the dispute of each item being appealed (additional pages may be submitted as necessary)			
Statement of remedy sought, including a computation and the dollar amount of your claim for each disputed item (additional pages may be submitted as necessary)			

In order to appeal a denial, reduction, recoupment or an adjustment of payment, this completed form, **including the remittance advice or notice of recoupment or adjustment,** must be received within 30 days of the date of the Department's remittance advice, or notice of recoupment or adjustment.

Submit to:

Appeals Supervisor
Department of Health and Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

All documents, written statements, exhibits, and other written information that support the appeal must be submitted to the Department within 30 days of your request for appeal. A copy of this completed form must be attached to any additional information you submit to the Department. Refer to N.D.C.C. 50-24.1-24 for additional information.