NORTH DAKOTA MEDICAID PROVIDER APPEAL

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LEGAL ADVISORY UNIT
SFN 168 (7-2015)

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 / Date of Notice (enclose a copy)		
Reason for appealing denial or reduction in level of service payment from the North Dakota Medicaid program (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 or reduction of payment, this completed form must be submitted within 30 days of the date of the Department's remittance advice or notice.

Submit to:

North Dakota Department of Human Services
Appeals Supervisor
State Capitol - Judicial Wing
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.