REQUEST FOR REHABILITATIVE SERVICES FOR MEDICAID ELIGIBLE ENROLLEES

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1853 (10-2012)

Clear Fields

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Entity Requesting Approval		Entity Contact Telephone Number
Signature of Individual Submitting this Request		Date

☐ Initial Request
☐ Six-Month Extension - Provide first authorization date for this recipient for rehabilitative services: _____

The following requirements must be met before rehabilitative services can be provided through the North Dakota Medicaid Program. Please initial all of the items below that apply:

_____ The recipient is currently eligible for the North Dakota Medicaid program.

_____ The service is recommended by a practitioner of the healing arts within the scope of their practice under State law by a provider affiliated with the Department of Human Services.

_____ The recipient has a mental health or substance abuse disorder, and meets one of the following circumstances (please initial all that apply):

- _____ The recipient is at risk of entering or reentering a mental health facility or hospital; OR
- _____ The recipient requires medication management and consultation to ensure the maintenance of his/her best functioning level.

_____ The recipient is from a family that is in crisis and at risk of major dysfunction that could lead to (please initial all that apply):

- _____ Disruption of the current family makeup or in a family that has experienced a interference that has resulted in an interruption of the family; OR
- _____ The recipient is in need of mental health, substance abuse or behavioral intervention and management services that are provided by qualified practitioners who are part of an enrolled entity; OR
- _____ The recipient has recently been released from the State mental facility into a transitional residential setting of not more than 16 beds.

If this is an extension of services, please include a copy of the recipients records to support this request. Records should include the initial intake, progress notes, and the plan of care. Items that should be detailed in the recipients plan of care include:

- Name
- Age
- Family composition
- Current residency
- Education level or current educational setting
- Work status/employment
- Placement history (including facility, admission and discharge date)
- Narrative history or background of recipient
- Presenting concerns
- Diagnosis (if applicable-all Axes); upon intake, documentation of the symptoms to justify the diagnosis
- Behavioral patterns

Continued on next page

- Names of practitioners that are providing care/services to the recipient
- Legal responsible party
- Treatment goals/primary plan of action
- Summary of progress/goals
- Medical needs (if available)
- Current health status (if available)
- Medication list (if available)
- Immunization record (if available)
- Recent medical appointments (if available)

Documentation must be legible and clearly identify the necessity of the services. The recipients ongoing goals and progress notes must be easily recognizable.

This form and documentation should be mailed or faxed to:

Medical Services Division
600 East Boulevard Avenue, Department 325
Bismarck, ND 58505
701.328.1544

Medical Services Approval

Name	Date
Dates of Approval From: To:	