

1915(i) REQUEST FOR SERVICE PROVIDER

North Dakota Department of Health & Human Services

Medical Services Division

Rev (7/2023)

This form is utilized by the care coordinator to request service providers as identified by the member during plan of care development, when a member requests a transfer from one provider to another, or when a provider terminates services for a member. Submit one form for each request.

Attach the 1915(i) Person-Centered Plan of Care to this form and send to each provider. For transfers and terminations, the form must also be sent to the State at nd1915i@nd.gov.

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		
Name (Last, First, MI)		Phone Number
Medicaid Type <input type="checkbox"/> Traditional <input type="checkbox"/> Expansion		Traditional or Expansion Medicaid ID #
Request Type		
<input type="checkbox"/> Service Provider <input type="checkbox"/> Transfer of Services <input type="checkbox"/> Termination of Services		
Service Requested		
<input type="checkbox"/> Care Coordination <input type="checkbox"/> Benefits Planning Services <input type="checkbox"/> Family Peer Support <input type="checkbox"/> Housing Support (Pre-tenancy) <input type="checkbox"/> Housing Support (Tenancy) <input type="checkbox"/> Non-Medical Transportation <input type="checkbox"/> Peer Support <input type="checkbox"/> Pre-Vocational Training <input type="checkbox"/> Respite Care <input type="checkbox"/> Supported Education <input type="checkbox"/> Supported Employment <input type="checkbox"/> Training and Support for Unpaid Caregivers* <input type="checkbox"/> H0039 code/15 minutes and/or <input type="checkbox"/> 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	Agency	Phone	Email
Signature		Date Request Sent	

Service Provider	
<i>1st Choice</i>	
Provider	
Phone	Email
<input type="checkbox"/> I accept this request.	<input type="checkbox"/> I deny this request.
Reason(s) for Denial	
Signature of Provider	Date
<i>Return form to care coordinator via email. Transfer and termination requests must also be sent to the State at nd1915i@nd.gov.</i>	

<i>2nd Choice</i>	
Provider	
Phone	Email
<input type="checkbox"/> I accept this request.	<input type="checkbox"/> I deny this request.
Reason(s) for Denial	
Signature of Provider	Date
<i>Return form to care coordinator via email. Transfer and termination requests must also be sent to the State at nd1915i@nd.gov.</i>	

<i>3rd Choice</i>	
Provider	
Phone	Email
<input type="checkbox"/> I accept this request.	<input type="checkbox"/> I deny this request.
Reason(s) for Denial	
Signature of Provider	Date
<i>Return form to care coordinator via email. Transfer and termination requests must also be sent to the State at nd1915i@nd.gov.</i>	