51784

North Dakota Department of Human Services

GROUP AUTHORIZATION & REQUEST FOR PAYMENT

MEDICAL ASSISTANCE PROGRAM - BASIC CARE FACILITY

Provider Number

Provider Name

Provider Address

City State Zip

Providers: Retain a copy for your records.

Recipient ID Number - -

Recipient Name:

Authorization Period M M / D D / Y Y **through** M M / D D / Y Y

Patient Account Number

Admit Date M M / D D / Y Y **Discharge Date** M M / D D / Y Y

Discharge Code

Other Insurance .

Service Code	From Day	Through Day	Service Code	From Day	Through Day	Service Code	From Day	Through Day
	TH	TH		TH	TH		TH	TH
	TH	TH		TH	TH		TH	TH
	TH	TH		TH	TH		TH	TH
	TH	TH		TH	TH		TH	TH

Certification and Agreement of Providers: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from state fund sand county funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws. That the services herein charged were actually rendered and were rendered under the conditions specified; and that no part of such bill, claim, account or demand has been paid. I further certify that goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Basic Care Assistance Program as set forth under North Dakota Century Code 50-24.5. and to furnish the state agency with such information, regarding any payments claimed by such person or institution for providing services under 50-24.5., as the state agency may from time to time request.

Provider Signature: _____ Date: _____