VERIFICATION OF DIAGNOSIS MEDICAID REFERRAL

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY AND HEALTH SYSTEMS
SFN 52957 (3-2020)

Name of Patient	Patient ID Number	Date of Birth
Name of Health Care Facility		

Date of Diagnosis	Diagnosis
Treatment Plan	
Name of Health Care Provider	
Signature of Health Care Provider	Date

Name of *Women's Way* Local Coordinator (Print)	
Signature of *Women's Way* Local Coordinator	Date