



**SECURE MAIL TRANSMITTAL**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 DIVISION OF COMMUNITY AND HEALTH SYSTEMS  
 SFN 51653 (8-2020)

**TO:** Blue Cross Blue Shield ND **Email:** [enrollment.changes@bcbsnd.com](mailto:enrollment.changes@bcbsnd.com)

**FROM:** Women's Way Staff Contact Information:

Women's Way Group Number	Name		
Address	City	State	ZIP Code
Email Address		Telephone Number	

**CLIENT INFORMATION**

Check Appropriate Box <input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-enrollment (use this box if client has been previously enrolled in the program) <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change		Women's Way UMI Number  Client Enroll/Re-enroll Date
Client Name	Social Security Number *	Client Date of Birth

\* Disclosure of the full Social Security Number (SSN) is not required; however, new clients may not be covered immediately without it; application without SSN will need to be hand processed; which requires more time.

Address	City	State	ZIP Code
Previous Names (if any)			
Action <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Change Group <input type="checkbox"/> Other (specify): _____			
Comments			

**CLIENT INSURANCE INFORMATION**

- Client is over age 65, but is ineligible for or unable to enroll in Medicare Part B  
 If client is over age 65, client must provide Medicare Part A Insurance Number (HIB) \_\_\_\_\_
- Does not have health insurance
- No longer has health insurance (for re-enrollees who previously had health insurance). **Insurance coverage has ended.**  
 Provide information for previous health insurance below.
- Is currently covered by a health insurance plan
- Change in insurance

Name of Policy Holder	Policy Holder Date of Birth	
Name of Insurance Company	Benefit Plan Number	Telephone Number

*I verify that the Authorization for Disclose of Protected Health Information has been received from the above-named client. If you have any questions or desire as copy of the release, contact me at the location or telephone number listed above.*

Signature	Date
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\* According to the Privacy Act of 1974, this it to let Women's Way clients know that the disclosure of a social security number to Women's Way is voluntary and it is requested for identification purposes only. Failure to disclose this information will not affect participation in this program.