1915(i) REQUEST FOR SERVICE PROVIDER

North Dakota Department of Health & Human Services
Medical Services Division
Rev (4-2024)

This form is utilized by the care coordinator to request service providers as identified by the member during plan of care development, or when a member requests a transfer from one provider to another. 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, 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 ☐ Traditional ☐ Expansion	Traditional or Expansion Medicaid ID #

Request Type
☐ Service Provider ☐ Transfer of Services

Service Requested
☐ Care Coordination ☐ Benefits Planning Services ☐ Family Peer Support ☐ Housing Support (Pre-tenancy) ☐ Housing Support (Tenancy) ☐ Non-Medical Transportation ☐ Peer Support ☐ Pre-Vocational Training ☐ Respite Care ☐ Supported Education ☐ Supported Employment ☐ Training and Support for Unpaid Caregivers* ☐ H0039 code/15 minutes and/or ☐ 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 *1st Choice*	
Provider	
Phone	Email
☐ I accept this request.	☐ I deny this request.
Reason(s) for Denial	
Signature of Provider	Date
Return form to care coordinator via email. Transfer requests must also be sent to the State at nd1915i@nd.gov	

2nd Choice	
Provider	
Phone	Email
☐ I accept this request.	☐ I deny this request.
Reason(s) for Denial	
Signature of Provider	Date
Return form to care coordinator via email. Transfer requests must also be sent to the State at nd1915i@nd.gov	

3rd Choice	
Provider	
Phone	Email
☐ I accept this request.	☐ I deny this request.
Reason(s) for Denial	
Signature of Provider	Date
Return form to care coordinator via email. Transfer requests must also be sent to the State at nd1915i@nd.gov	