MEDICAID QUESTIONNAIRE AND ASSIGNMENT

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 566 (3-2013)

NOTICE: Medicaid has made or may make payment for services provided to you. The following information is necessary to determine if other sources of payment are available for recovery of Medicaid funds. It is the applicant or eligible client's responsibility to take reasonable measures to identify and report resources and assist the Department in obtaining information and payment from these resources. To assure continued benefits, please return this form within 30 days of receipt.

All questions must be answered in the applicable sections and your signature must be entered on the reverse side where indicated.

SECTION I - CLIENT INFORMATION

Full Name		Telephone Number	
Mailing Address (Street)	City	State	ZIP Code
Medicaid Case Number	Medicaid ID Number		
Other Family Members Injured			
Date of Accident	Time of Accident	Injuries Received	
Where did accident occur? ☐ Work ☐ Auto ☐ Home ☐ School ☐ Other _____			
Address/Location of Accident			
Attorney Name (if applicable)	Attorney Telephone Number (if applicable)		

SECTION II - IF VEHICLE ACCIDENT

A. Were you ☐ Driver ☐ Passenger ☐ Pedestrian			
Name of Policyholder	Name of Insurance Company		
Policy Number	Claim Number		
Address to Send Claim		Telephone Number	
B. Type of vehicle which struck you or the car in which you were riding: ☐ Auto ☐ Motorcycle ☐ Other _____			
Name of Driver		Telephone Number	
Address	City	State	ZIP Code
Owner of Vehicle		Telephone Number	
Address	City	State	ZIP Code
Name of Insurance Company		Telephone Number	
Policy Number	Claim Number		
Do you or other family member or other living in household own a vehicle? ☐ Yes ☐ No			

SECTION II - IF VEHICLE ACCIDENT (CONT)

Name of Insurance Company		Telephone Number
Policy Number	Claim Number	
Name of Insured		

SECTION III - OTHER TYPE OF ACCIDENT

Location	
Business, Homeowner or Other Name	
Name of Insurance Company	
Policy Number	Claim Number

SECTION IV - WORKERS COMPENSATION

Name of Employer			Company Telephone Number	
Department of Work				
Employee Number	Type of Injury		Date of Injury	
Have you filed a claim for Workers Compensation?	☐ Yes ☐ No			
If yes, are you presently receiving benefits?	☐ Yes ☐ No			
If not receiving benefits, is your claim pending?	☐ Yes ☐ No			
Do you have an attorney?	☐ Yes ☐ No			
Name of Attorney			Telephone Number	
Address	City		State	ZIP Code
What are your specific injuries related to this accident?				
Workers Compensation Claim Number				

MEDICAID ASSIGNMENT OF BENEFITS

In consideration of Medical Assistance rendered by the North Dakota Medicaid Program, I hereby assign to the North Dakota Department of Human Services all rights to benefits otherwise payable to me for hospital, surgical or medical services rendered to myself or any of my dependents, and I authorize payment of said benefits directly to the North Dakota Department of Human Services, the state Medicaid agency. I fully understand this assignment and acknowledge that I have an obligation to reimburse the state of North Dakota for hospital and medical expenses paid on my behalf or on the behalf of my dependents, in the event I have a right of recovery under any policy of insurance, or against any person who may be liable for the medical expenses.

Printed Name	
Signature	Date