1915(i) Care Coordination Request Report

Blue Cross Blue Shield of North Dakota Medicaid Expansion
1915(i) Form

Immediately upon completion, submit the form by:

- Email: 1915i@bcbsnd.com

Care coordination agencies:

- Fill out this form to inform 1915(i) staff that you are accepting a member for care coordination services. Report the date the member made initial contact with you regarding 1915(i) Care Coordination services. This means contact made independently by the member or a parent/legal guardian and the care coordination agency. Upon receipt of this form, 1915(i) staff will provide the Care Coordinator with the 1915(i) and Medicaid eligibility information necessary for Plan of Care development. DO NOT use this form to transfer care coordination services between provider agencies.

  Care coordination agencies must respond to the member within five (5) business days of the first call or contact by the member or a parent/legal guardian.

Provider Agency Information	
Agency Name	Agency Phone Number
Care Coordinator Name	Care Coordinator Email

Member Information	
Name	Phone Number
Parent/Guardian Name (if applicable)	Parent/Guardian Phone Number (if applicable)

Contact Record	
Date Member First Contacted Provider Agency	Date Provider Agency Attempted Initial Follow-up
Date(s) Provider Agency Attempted Additional Follow-up	

Result of Contact/Provider Agency Decision

☐ Not able to contact member within five (5) days of initial contact

☐ Provider agency has notified member of request being approved

Date of notification: _____ Method of notification: _____

☐ Provider agency has notified member of request being denied

Date of notification: _____ Method of notification: _____

Reason for denial:

Signature of Provider Agency Representative	Date

Effective January 1, 2025