1915(i) Member Discharge Form

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

Submit the form to Blue Cross Blue Shield of North Dakota (BCBSND) by:

- Email: 1915i@bcbsnd.com

Member Information

Member Name	Member Medicaid ID#
Member Contact Information (phone number and/or email)	

Agency Information

Name	Contact Name
Contact Phone Email	Contact Phone Number

Service Requested *(select the applicable service)*

- ☐ Care Coordination Housing Support* SA#:
- ☐ Peer Support* SA#:
- ☐ Benefits Planning* SA#:
- ☐ Family Peer Support* SA#:
- ☐ Non-Medical Transportation* SA#:
- ☐ Supported Education* SA#:
- ☐ Supported Employment* SA#:
- ☐ Respite* SA#:
- ☐ Pre-Vocational Training* SA#:
- ☐ Training and Support for Unpaid Caregivers* SA#:

* For the service selected, please provide the date and the method used to notify the care coordinator of discharge below.

Effective Date of Discharge	How and When was Member Notified

Briefly Describe Reason for Discharge

Describe Efforts to Connect Member with Another Provider of Their Choice

*Date and Method Used to Notify Care Coordinator of Discharge

Effective January 1, 2025