# SECURE MAIL TRANSMITTAL

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH PROMOTION & CHRONIC DISEASE PREVENTION
SFN 51653 (2-2023)

**TO:** Blue Cross Blue Shield ND **Email Current BCBS Enrollment Representative**

**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<br>☐ New Enrollment<br>☐ Re-enrollment (use this box if client has been previously enrolled in the program)<br>☐ Name Change ☐ Address Change | | *Women's Way* UMI Number<br>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<br>☐ Cancel Coverage ☐ Change Group ☐ 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 |
|---|---|

* 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.