



North Dakota Retrospective Review Request Form

Date: _____

To: DDM Ascend
ND Under 21 Review Team
227 French Landing Drive, Suite 250
Nashville, TN 37228

Re: Recipient Name _____ DOB _____

Facility/Provider _____

Facility Address _____

City _____ State _____ Zip _____

County _____ Fax _____ Phone _____

Type of Review Requested (care provided): Residential Acute

I am requesting retrospective review of the above named individual who has applied for Medicaid benefits following receipt of treatment services. I am enclosing the complete medical record.

Signature of Provider Representative: _____

Printed Name: _____ Credentials: _____