



# ND RYAN WHITE PROGRAM PART B REQUEST FOR OUT-OF-STATE TREATMENT

NORTH DAKOTA DEPARTMENT OF HEALTH

DIVISION OF DISEASE CONTROL

SFN 58586 (11-13)

Client's Name		ND Ryan White Client Number	
Date Form Completed			
Instructions			
<ul style="list-style-type: none"><li>• A detailed explanation must be written by health care provider stating why the client is being referred to an out-of-state provider.</li><li>• In order for approval there must be a legitimate reason a health care provider in North Dakota is not able to take care of the medical problem.</li><li>• Obtain signatures from your health care provider and case manager.</li></ul>			
Treatment Requested			
<hr/> <hr/>			
Out-of-State Treatment Facility		Telephone Number	
Street Address			
City		State	Zip Code
Explanation for Referral (to be completed by health care provider)			
<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			
Signatures			
<hr/> Health Care Provider		<hr/> Date	
<hr/> Client		<hr/> Date	
<hr/> Case Manager		<hr/> Date	
ND Ryan White Program Part B Coordinator Approval/Denial			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied			