



ND Medicaid Provider Enrollment

Individual Provider Enrollment

North Dakota Department of Human Services

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Medicaid Provider Enrollment

Individual Provider Enrollment

Individual Provider Introduction

Procedure

Access ND MMIS Web Portal:

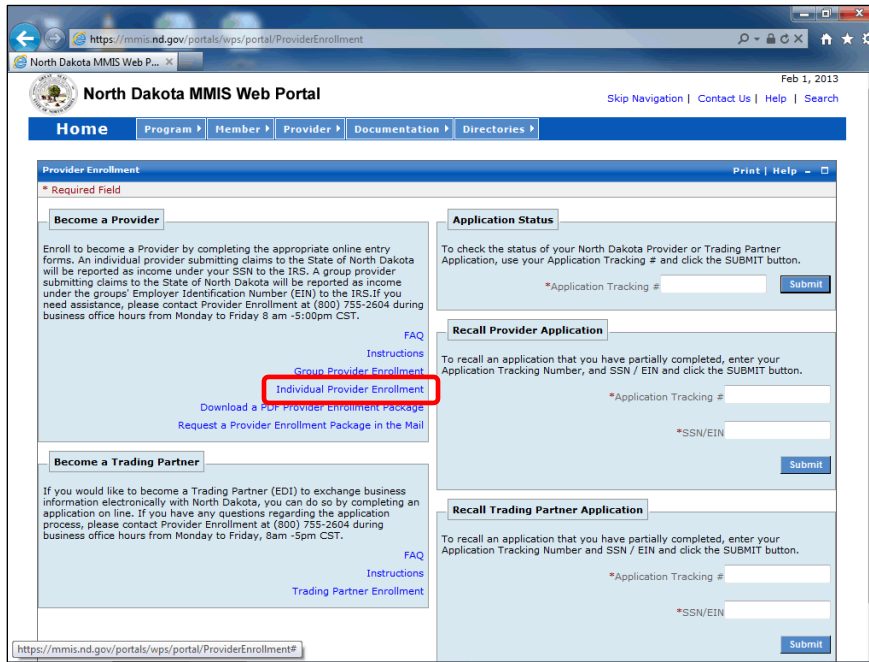
<https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment>

The screenshot shows the North Dakota MMIS Web Portal interface. At the top left is the state seal and the text "North Dakota MMIS Web Portal". At the top right, it says "MBF 2b, 2014" and "Skip Navigation | Contact Us | Help | Search". Below this is a blue navigation bar with "Home" and dropdown menus for "Program", "Member", "Provider", "Documentation", and "Directories". The main content area is titled "Provider Enrollment" and includes a "Print | Help" link. A red asterisk indicates a required field. The page is divided into four main sections: "Become a Provider", "Application Status", "Become a Trading Partner", and "Recall Trading Partner Application". Each section contains descriptive text and links to FAQs, instructions, and enrollment forms. The "Application Status" and "Recall Trading Partner Application" sections include input fields for "Application Tracking #" and "SSN/EIN" with "Submit" buttons.

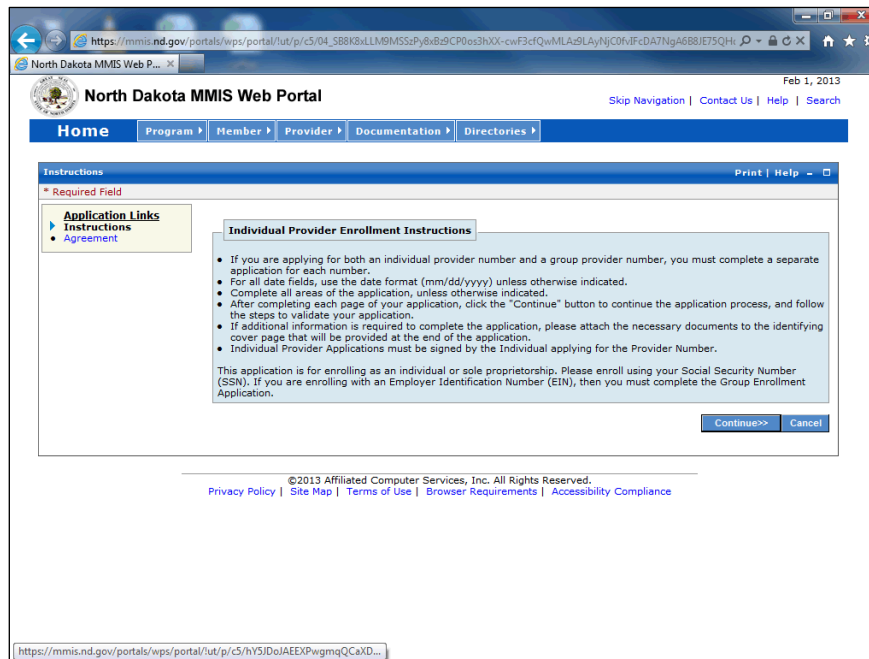
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Step	Action
1.	Click the Individual Provider Enrollment link. Individual Provider Enrollment

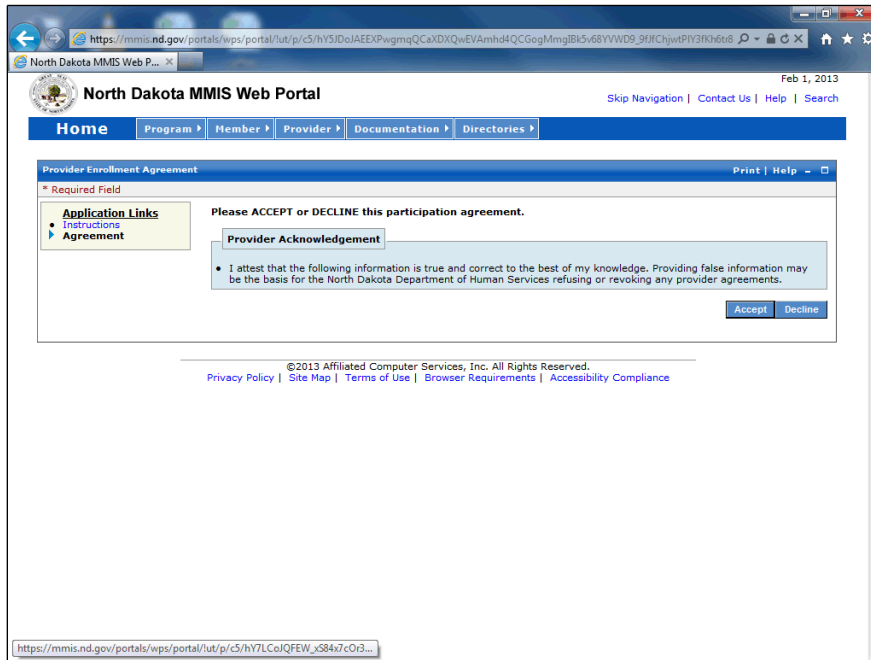



Step	Action
2.	Click the Continue>> button. It is very important to read all on-screen instructions and notes

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Step	Action
3.	<p>Click the Accept button.</p> <p>This will take you to the first section of the Enrollment Application: Identifying Information</p> 
Step	Action
4.	<p>The next section will take you through how to complete the Identifying Information page.</p> <p>End of Procedure.</p>

Identifying Information Procedure

Identifying Information - Section 1

*Last Name *First Name MI Suffix Title

*Date of Birth

*Gender *Can information about date of birth and gender be available to clients?
 Male Female Yes No

*SSN

Note:Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.

Current/Previous ND Provider #

? Please enter your current and/or previous ND Provider numbers. Add Previous Provider ID

Previous ND Provider IDs

ND Provider ID #

Previous Names

Have you used any previous names in the past five years?
 Yes No

Step	Action
1.	Enter the desired information into the Last Name field.
Step	Action
2.	Enter the desired information into the First Name field.
Step	Action
3.	Enter the desired information into the Date of Birth field.
Step	Action
4.	Click the Male or Female option.
Step	Action
5.	Click the Yes or No option for the question "Can information about date of birth and gender be available to clients".
Step	Action
6.	Enter the desired information into the SSN field.

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Identifying Information - Section 1

*Last Name: Smith | *First Name: Tim | MI: | Suffix: | Title: |

*Date of Birth: 12/15/1960

*Gender: Male Female | *Can information about date of birth and gender be available to clients? Yes No

*SSN: 505-55-5555

Current/Previous ND Provider #

? Please enter your current and/or previous ND Provider numbers.

Previous ND Provider IDs

ND Provider ID #

Previous Names

Have you used any previous names in the past five years?
 Yes No

Add Previous Provider ID (highlighted with a red box)

Previous ND Provider IDs

ND Provider ID #

Add Previous ND Provider IDs (highlighted with a red box) | Save | Reset | Cancel

*ND Provider ID #

Step	Action
7.	Click the Add Previous Provider ID button. By selecting any "ADD" options, additional fields open that need to be completed. Add Previous Provider ID (highlighted with a red box)
8.	Enter the desired information into the ND Provider ID # field This is current/previous ND Medicaid numbers. Enter only <u>one</u> Medicaid number.
9.	It is Very Important to always click Save within each additional information window pane
10.	Click the Save link. Save (highlighted with a red box)

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your IRS form w9.

Date of Birth
MM/DD/YYYY or click the Calendar icon to choose a date.

SSN
Enter as 9 digits with or without dashes

Current/Previous ND Provider # :
To enter your Current and/or Previous ND Provider #, click the 'Add Previous ND Provider #' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row

Previous Names:
Answer the question. Additional information will be required if your response is Yes.

Click the **Save** button at the bottom of the page to validate the page content and save the information. Click the **Continue** button to move onto to the next step. if you choose to **Exit Application**, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

If you have any questions, please contact Provider Enrollment at (800) 755-2604.

System successfully saved the Information.

Previous ND Provider IDs Add Previous Provider ID

ND Provider ID #
000012345

1 - 1 of 1

Previous Names

Have you used any previous names in the past five years?

Yes No

Continue>> Reset Save Exit Application

Step	Action
11.	Click the Previous Names Yes or No option.
Step	Action
12.	Click the Save button.

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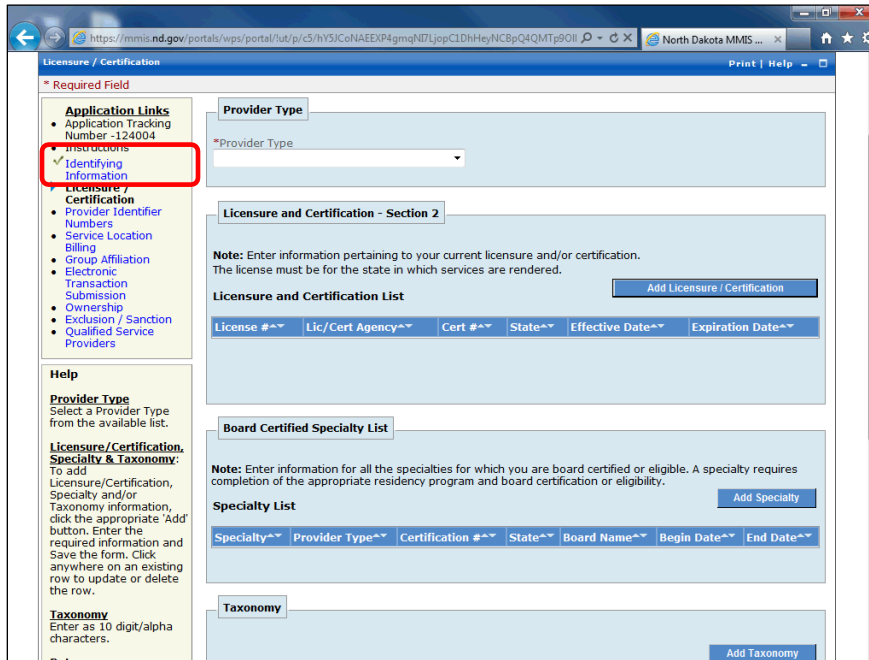
The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/lu/p/c5/hv5jD0AEEpVgmqmiHHZ0B1MhFYmBTYE4sCIDAuC>. The page title is "Identifying Information". A red box highlights a message: "Required Field The Provider Enrollment Details have been saved successfully. Please note your Application Tracking number 124004 for future access to the enrollment Application." Below this, the form is titled "Identifying Information- Section 1". It contains fields for Last Name (Smith), First Name (Tim), MI, Suffix, Title, Date of Birth (12/15/1960), Gender (Male), and SSN (505555555). There is a note about SSN linking to the ND Provider number. Below the form, there is a section for "Current/Previous ND Provider #" with a text input field containing "000012345" and a button "Add Previous Provider ID". At the bottom, there are buttons for "Continue>>", "Reset", "Save", and "Exit Application".

Step	Action
13.	After selecting SAVE, the application tracking number (ATN) will be displayed at the top of the page. It is important to write this number down and keep it for future reference. The ATN is required when submitting any documentation and/or inquiries to the Department.

This screenshot shows the bottom portion of the "Identifying Information" form. It includes the "Current/Previous ND Provider #" section with the value "000012345" and the "Add Previous Provider ID" button. Below this is the "Previous Names" section with a question: "Have you used any previous names in the past five years?" and radio buttons for "Yes" and "No". At the bottom right, there are four buttons: "Continue>>" (highlighted with a red box), "Reset", "Save", and "Exit Application". The URL at the bottom of the browser window is <https://mmis.nd.gov/portals/wps/portal/lu/p/c5/hv5jC0NAEEpP4gmqN7Ljo...>

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Step	Action
14.	Click the Continue>> button. <div style="text-align: center; border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Continue>> </div>



Step	Action
15.	Clicking continue will bring you to the next section to be completed.
Step	Action
16.	The next section will take you through how to complete the Licensure / Certification page. End of Procedure.

Licensure/Certification

Procedure

Provider Type: Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

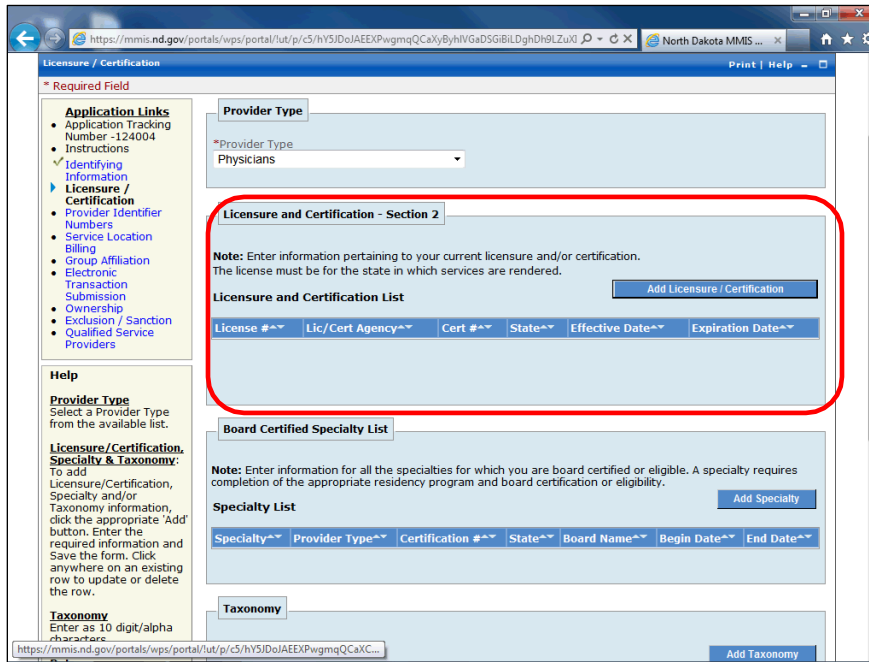
The screenshot shows the North Dakota MMIS Web Portal interface. The main content area is titled 'Licensure / Certification'. A dropdown menu for 'Provider Type' is highlighted with a red box. Below this, there are sections for 'Licensure and Certification - Section 2' and 'Board Certified Specialty List'. The 'Licensure and Certification List' table has columns for License #, Lic/Cert Agency, Cert #, State, Effective Date, and Expiration Date. The 'Board Certified Specialty List' table has columns for Specialty, Provider Type, Certification #, State, Board Name, Begin Date, and End Date. A sidebar on the left contains 'Application Links' and 'Help' sections.

Step	Action
1.	Click the Provider Type list.
Step	Action
2.	Select the Appropriate provider type.

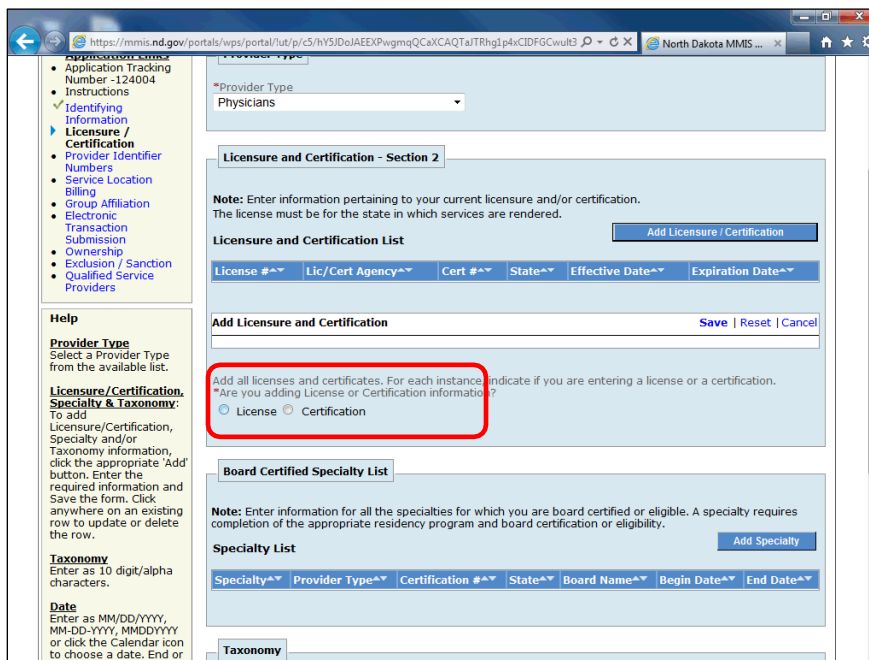
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Step	Action
3.	Section 2 – <u>L</u>icense is required.
Step	Action
4.	Click the Add Licensure / Certification button.



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Step	Action
5.	Click the License or Certification option.

Step	Action
6.	Enter the desired information into the License # field. If the license does not have an assigned number, enter '00000'.
Step	Action
7.	Click the Licensing Agency list.
Step	Action
8.	Click the Appropriate Licensing Agency list item.
Step	Action
9.	Enter the Effective Date .
Step	Action
10.	Enter the Expiration Date .
Step	Action
11.	Click the Save button. <input type="button" value="Save"/>
Step	Action
12.	If the provider has multiple License/Certifications, repeat steps 4 -11.

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The screenshot shows the 'Licensure and Certification' section of the Medicaid Provider Enrollment system. A red box highlights the 'Licensure and Certification List' table, which contains the following data:

License #	Lic/Cert Agency	Cert #	State	Effective Date	Expiration Date
LN45339990	State Board of Medical Examiners		North Dakota	12/01/2009	12/31/2014

The table is labeled '1 - 1 of 1'. Below the table is an 'Add Licensure / Certification' button. The rest of the form includes sections for 'Board Certified Specialty List' and 'Taxonomy', each with an 'Add' button.

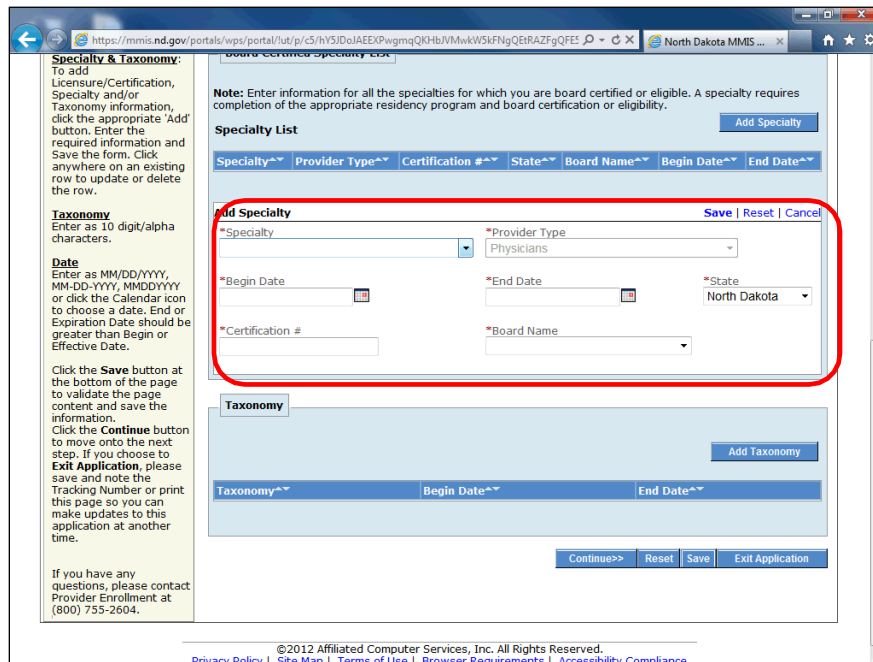
Specialty: Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

Step	Action
13.	<p>Click the Add Specialty button.</p> <p>Add Specialty</p> <p>*A specialty type is required for all enrollments.</p>

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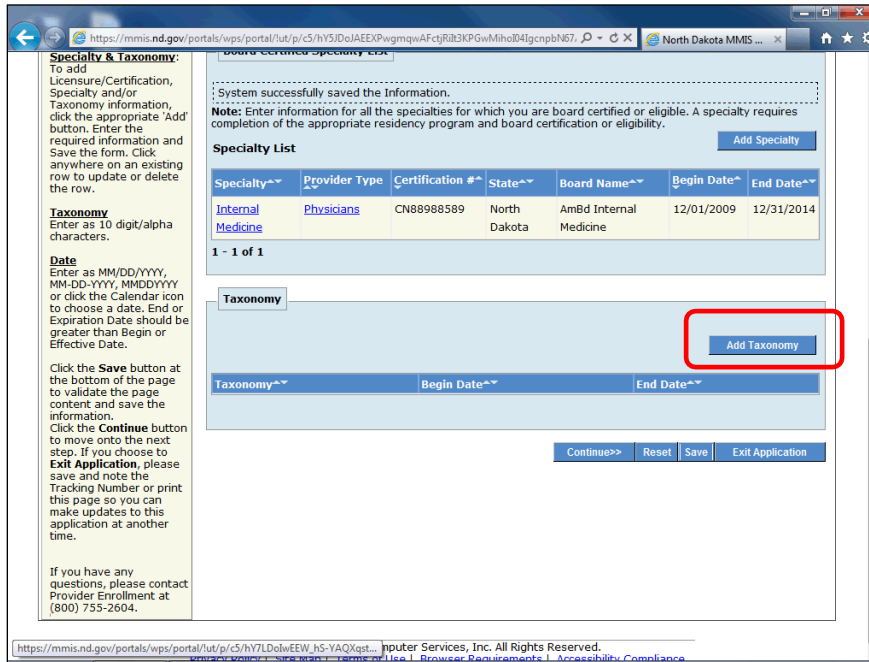
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Step	Action
14.	Click the Specialty list.
Step	Action
15.	Select the Appropriate Specialty list item.
Step	Action
16.	Enter the Begin Date .
Step	Action
17.	Enter the End Date . Enter 12/31/9999 .
Step	Action
18.	Enter the desired information into the Certification # field. If the certification does not have an assigned number, enter '00000'.
Step	Action
19.	Click the Board Name list.
Step	Action
20.	Select the Appropriate Board name list item.
Step	Action
21.	Click the Save link. Save

Taxonomy: Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes:
<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>



Step	Action
22.	<p>Click the Add Taxonomy button.</p> <div style="border: 1px solid black; display: inline-block; padding: 2px 10px; background-color: #4f81bd; color: white; margin: 5px 0;">Add Taxonomy</div> <p>*A Taxonomy code is required for all providers except Atypical providers (QSP's, Transportation, and Developmental Disabilities).</p>

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Specialty & Taxonomy:
To add Licensure/Certification, Specialty and/or Taxonomy information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

Taxonomy
Enter as 10 digit/alpha characters.

Date
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.

Click the **Save** button at the bottom of the page to validate the page content and save the information. Click the **Continue** button to move onto the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

If you have any questions, please contact Provider Enrollment at (800) 755-2604.

Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility.

Specialty List Add Specialty

Specialty	Provider Type	Certification #	State	Board Name	Begin Date	End Date
Internal Medicine	Physicians	CN88988589	North Dakota	AmBd Internal Medicine	12/01/2009	12/31/2014

1 - 1 of 1

Taxonomy Add Taxonomy

Taxonomy	Begin Date	End Date
<div style="border: 2px solid red; padding: 5px;"> <p>Add Taxonomy Save Reset Cancel</p> <p>*Taxonomy (10 digits/alphas) <input type="text"/></p> <p>*Begin Date <input type="text"/></p> <p>End Date <input type="text"/></p> <p style="text-align: right;">Continue>> Reset Save Exit Application</p> </div>		

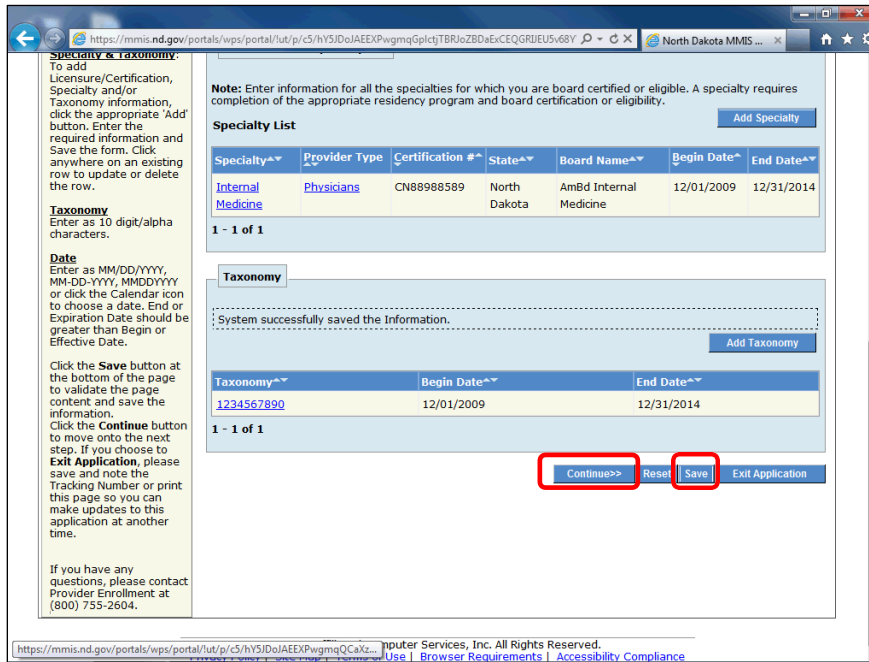
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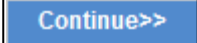
Step	Action
23.	Enter the desired information into the Taxonomy (10 digits/alphas) field.
Step	Action
24.	Enter the Begin Date .
Step	Action
25.	Enter the End Date . Enter 12/31/9999.
Step	Action
26.	Click the Save link. Save

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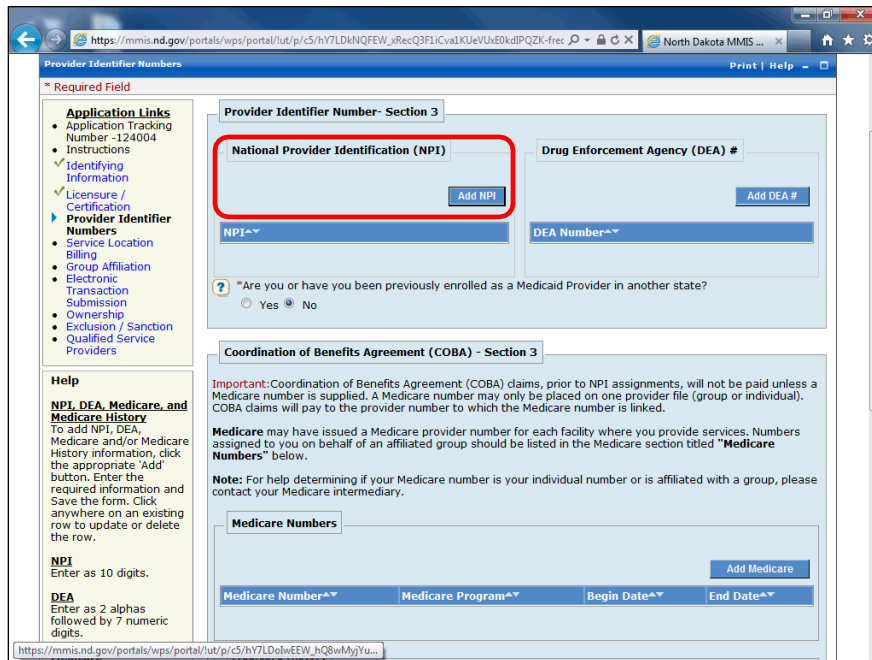
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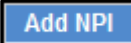
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Step	Action
27.	Click the Save button. 
Step	Action
28.	Click the Continue>> button. 
Step	Action
29.	The next section will take you through how to complete the Provider Identifier Numbers page. End of Procedure.

Provider Identifier Numbers Procedure



Step	Action
1.	Click the Add NPI button.  *Required for all providers except Atypical (QSP, Transportation, Meals, and Lodging) providers.

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The screenshot shows the 'Provider Identifier Numbers' section of the Medicaid Provider Enrollment system. The 'National Provider Identification (NPI)' field is highlighted with a red box, and the 'Add NPI' button is also highlighted. The 'Drug Enforcement Agency (DEA) #' field is also visible. The system is currently in 'Section 3' of the 'Provider Identifier Number' form.

Step	Action
2.	Enter the individual provider's NPI information into the NPI field.
Step	Action
3.	Click the Save link. Save

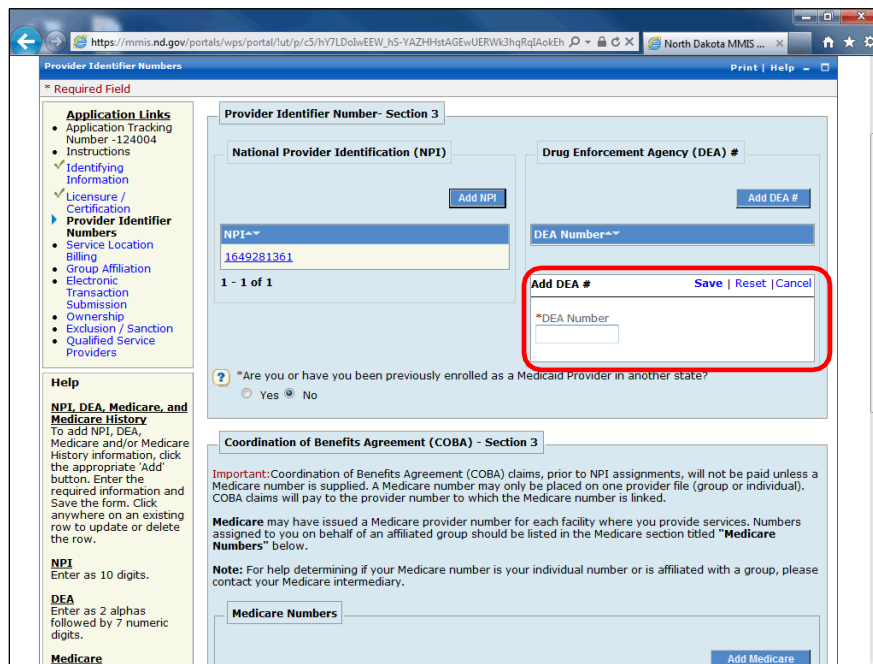
The screenshot shows the 'Provider Identifier Numbers' section of the Medicaid Provider Enrollment system. The 'Drug Enforcement Agency (DEA) #' field is highlighted with a red box. The NPI field now contains the value '1649281361'. The 'Add DEA #' button is also visible. The system is currently in 'Section 3' of the 'Provider Identifier Number' form. A message box indicates 'System successfully saved the Information.'

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Step	Action
4.	Click the Add DEA # button. Required for individuals with a DEA. <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">Add DEA #</div>



Step	Action
5.	Enter the individual provider's DEA information into the DEA Number field.
Step	Action
6.	Click the Save button. <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">Save</div>

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Step	Action
7.	Click the Yes or No option.
Step	Action
8.	If YES, select the Other Medicaid State from the list.

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Coordination of Benefits Agreement (COBA) - Section 3

Important: Coordination of Benefits Agreement (COBA) claims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA claims will pay to the provider number to which the Medicare number is linked.

Medicare may have issued a Medicare provider number for each facility where you provide services. Numbers assigned to you on behalf of an affiliated group should be listed in the Medicare section titled "**Medicare Numbers**" below.

Note: For help determining if your Medicare number is your individual number or is affiliated with a group, please contact your Medicare intermediary.

Medicare Numbers

[Add Medicare](#)



Medicare Number	Medicare Program	Begin Date	End Date
Add Medicare # Save Reset Cancel			
*Medicare Number		*Begin Date	*End Date
*Please check all that apply:			
<input type="checkbox"/> All <input type="checkbox"/> Medicare Program A <input type="checkbox"/> Medicare Program B <input type="checkbox"/> Medicare Program C <input type="checkbox"/> Medicare Program D			

Medicare History

For historical purposes, please list any Medicare Provider #(s) and Carrier/Intermediary #(s)

[Add History](#)

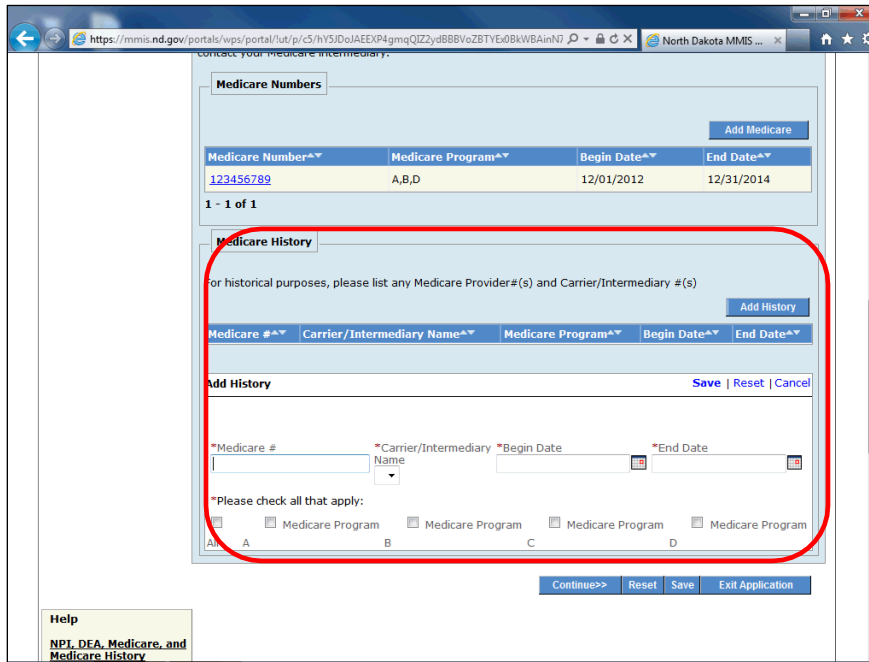
Medicare #	Carrier/Intermediary Name	Medicare Program	Begin Date	End Date
------------	---------------------------	------------------	------------	----------

Step	Action
9.	Click the Add Medicare button. 
Step	Action
10.	Enter the individual provider's Medicare information into the Medicare Number field.
Step	Action
11.	Enter the Begin Date .
Step	Action
12.	Enter the End Date . Enter 12/31/9999 .
Step	Action
13.	Check all Medicare Programs that apply.
Step	Action
14.	Click the Save button. 

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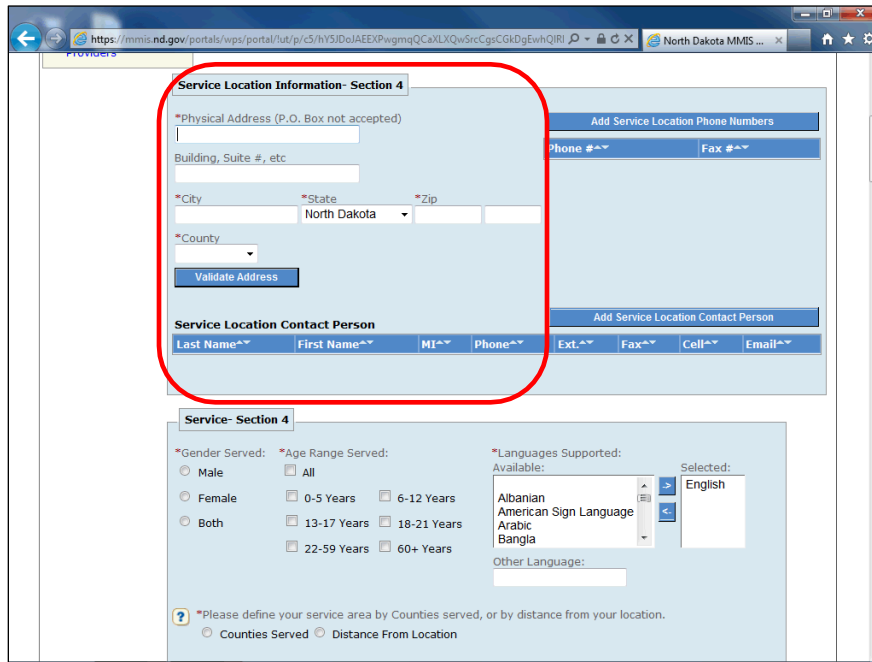


Step	Action
15.	Click the Add History button. Complete this section if you have been assigned a Medicare number in the past that is no longer in use. This section is for informational use only. <div style="text-align: center;">Add History</div>
Step	Action
16.	Enter the individual provider's Medicare information into the Medicare # field.
Step	Action
17.	Click the Carrier/Intermediary Name list.
Step	Action
18.	Enter the Begin Date .
Step	Action
19.	Enter the End Date .
Step	Action
20.	Check all Medicare Programs that apply.
Step	Action
21.	Click the Save button. <div style="text-align: center;">Save</div>
Step	Action
22.	Click the Continue>> button. <div style="text-align: center;">Continue>></div>

Step	Action
23.	The next section goes through how to complete the Service Location Billing section. End of Procedure.

Service Location Billing

Procedure

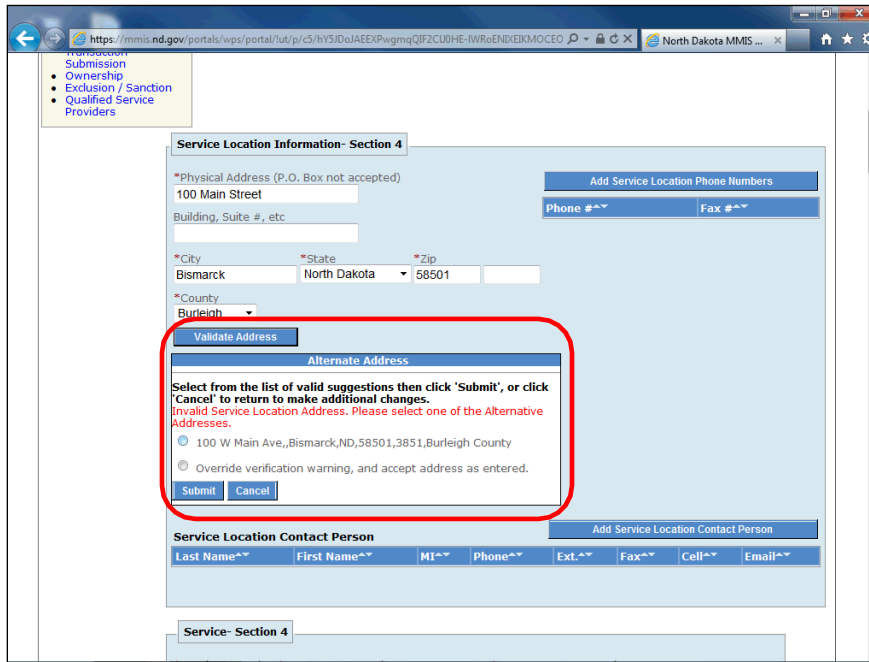


Step	Action
1.	Enter the desired information into the Physical Address (P.O. Box not accepted) field.
Step	Action
2.	Enter the desired information into the City field.
Step	Action
3.	Enter the desired information into the Zip field.
Step	Action
4.	Click the County list and select the appropriate County.

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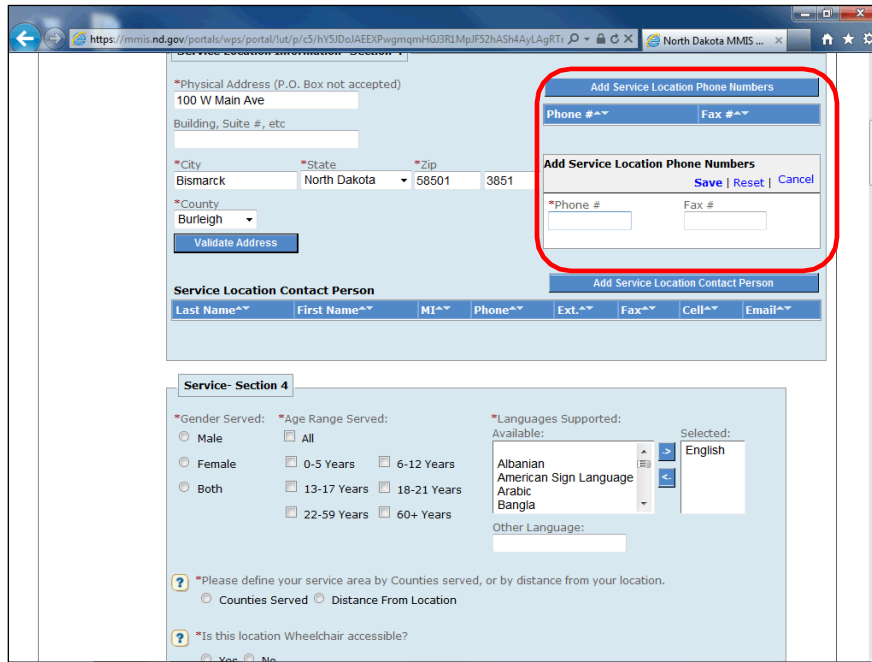


Step	Action
5.	Click the Validate Address button. <div style="border: 1px solid black; padding: 2px; display: inline-block; background-color: #4f81bd; color: white; text-align: center;">Validate Address</div>
Step	Action
6.	Click on the Appropriate address.
Step	Action
7.	Click the Submit button. <div style="border: 1px solid black; padding: 2px; display: inline-block; background-color: #4f81bd; color: white; text-align: center;">Submit</div>

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Step	Action
8.	Click the Add Service Location Phone Numbers button.
Step	Action
9.	Enter the desired information into the Phone # field.
Step	Action
10.	Click the Save link. Save

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The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/jsp/c5/hysj/DoJAEEpvgmqQCaXDiSYKOMAhtC4hCDDGES>. The page displays a form for adding a service location contact person. The form includes fields for physical address (100 W Main Ave), city (Bismarck), state (North Dakota), and zip (58501). Below these fields is a section titled "Service Location Contact Person" with a blue button labeled "Add Service Location Contact Person". This button and the form fields below it (Last Name, First Name, MI, Phone, Ext., Fax, Cell, Email, and Position) are circled in red. At the bottom of the form, there are radio buttons for gender (Male, Female) and age range (All, 0-5 Years, 6-12 Years), and a dropdown menu for languages supported (Albanian, English).

Step	Action
11.	Click the Add Service Location Contact Person button. Contact person and email address is required. 
Step	Action
12.	Enter the desired information into the Last Name field.
Step	Action
13.	Enter the desired information into the First Name field.
Step	Action
14.	Enter the desired information into the Phone field.
Step	Action
15.	Click the Position list and select the Appropriate list item.
Step	Action
16.	Click the Save link. 

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Service- Section 4

*Gender Served: Male Female Both

*Age Range Served: All 0-5 Years 6-12 Years 13-17 Years 18-21 Years 22-59 Years 60+ Years

*Languages Supported: Available: Albanian, American Sign Language, Arabic, Bangla. Selected: English

? *Please define your service area by Counties served, or by distance from your location. Counties Served Distance From Location

? *Is this location Wheelchair accessible? Yes No

? *Is this location TDD/TTY Equipped? Yes No

? *Does this location provide after-hours services? Yes No

? *Do you wish to be excluded from public provider searches? Yes No

? *Are you a 340b Provider? Yes No

Hours Of Operation: _____ Interpretive Services Available: _____

Step	Action
17.	Click the Appropriate Gender option.
Step	Action
18.	Click the Appropriate Age Range and Language options.

Service- Section 4

*Gender Served: Male Female Both

*Age Range Served: All 0-5 Years 6-12 Years 13-17 Years 18-21 Years 22-59 Years 60+ Years

*Languages Supported: Available: Albanian, American Sign Language, Arabic, Bangla. Selected: English

? *Please define your service area by Counties served, or by distance from your location. Counties Served Distance From Location

? *Is this location Wheelchair accessible? Yes No

? *Is this location TDD/TTY Equipped? Yes No

? *Does this location provide after-hours services? Yes No

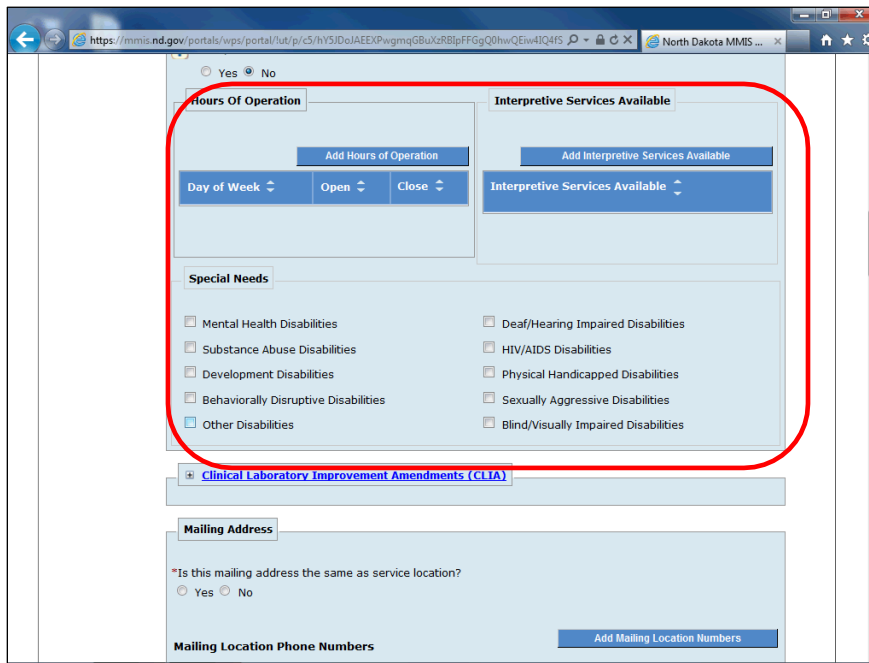
? *Do you wish to be excluded from public provider searches? Yes No

? *Are you a 340b Provider? Yes No

Hours Of Operation: _____ Interpretive Services Available: _____

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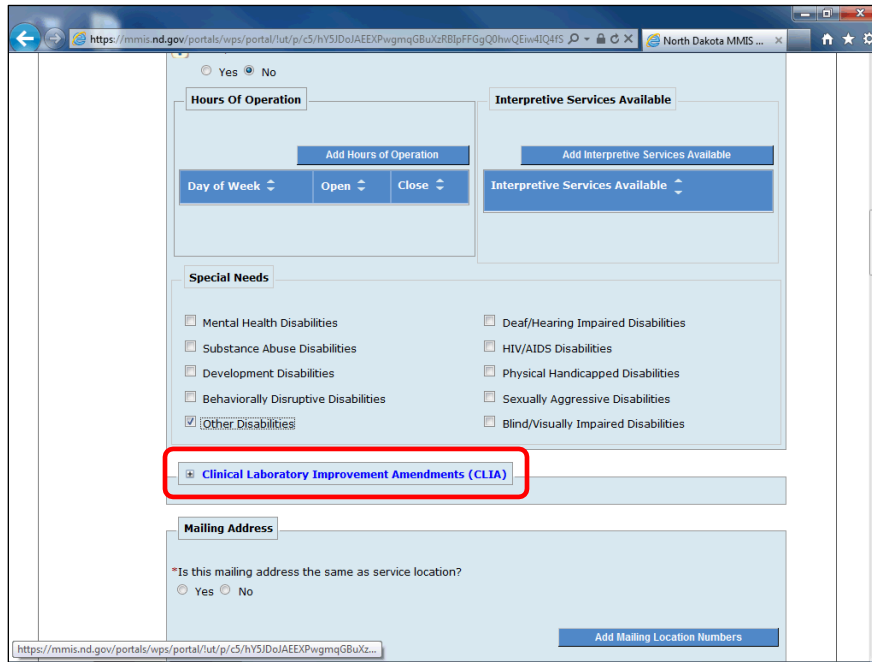
Step	Action
19.	Click the Counties Served or Distance From Location option.
Step	Action
20.	Click the Distance From Location or choose the Counties Served list.
Step	Action
21.	Click Yes or No on questions 1-6. Note: The question pertaining to 340b provider is for pharmacy providers only. Select the ‘No’ radio button.
Step	Action
22.	Hours of Operation, Interpretive Services, and Special Needs sections optional for individual enrollment applications.



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Step	Action
23.	CLIA section does not apply to individual enrollment applications. Skip this section.

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The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/!ut/p/c5/hYSJDoJAEEXPvgmqQCaXbUMwigW5IFNgQ4H3IDatC...>. The page title is "Clinical Laboratory Improvement Amendments (CLIA)". A message states "System successfully saved the information" with an "Add CLIA" button. A table displays the following information:

CLIA #^^	Begin Date^^	End Date^^
35D1055181	12/01/2012	12/31/2012

Below the table, it says "1 - 1 of 1". The "Mailing Address" section is highlighted with a red box and contains the question: "Is this mailing address the same as service location?" with radio buttons for "Yes" and "No". Below this is the "Mailing Location Phone Numbers" section with an "Add Mailing Location Numbers" button. Further down are sections for "Service Location Contact Person(s)" and "Mailing Location Contact Person" with an "Add Mailing Location Contact Person" button. At the bottom, there is a section for "Electronic Funds Transfer (EFT) Payments".

Step	Action
24.	Click the Yes or No on the Mailing Address option. If No , complete the Mailing Address information.
Step	Action
25.	Contact person and email address is required.

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Step	Action
26.	Click the Yes or No option for Electronic Funds Transfer Payments. This should only be completed if the individual will be submitting Medicaid claims as an Independent provider billing under the Social Security Number (SSN). If the individual is a rendering provider only, this section should be left blank. Do not enter the group EFT information on an individual application. Select 'No' if the individual will not be billing independently.
Step	Action
27.	If Yes, Enter the desired information into the Bank Name field.
Step	Action
28.	Enter the desired information into the Bank Address field.
Step	Action
29.	Enter the desired information into the City field.
Step	Action
30.	Click the State list.
Step	Action
31.	Enter the desired information into the Zip field.
Step	Action
32.	Enter the desired information into the Bank Routing Transit Number field.
Step	Action
33.	Enter the desired information into the Bank Account Number field.

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Step	Action
34.	Click the Account Type list.
Step	Action
35.	Enter the desired information into the Bank Phone # field.
Step	Action
36.	Enter the desired information into the Account Holder Name field.
Step	Action
37.	Enter the desired information into the Payee Provider's Name field.

The screenshot shows a web browser window with the URL https://mmis.nd.gov/portals/wps/portal/luk/p/c5/nY7LDolwEEW_h5-YQXkua2kwkVbLS2BD5FCjCgCoPT. The form fields are as follows:

- *Bank Routing Transit Number: 291378130
- *Bank Account Number: 000000000
- *Account Type: CHECKING ACCT
- *Bank Phone #: 701-555-5555
- *Account Holder Name: Smith
- *Payee Provider's Name: Smith

The **Billing Address** section is highlighted with a red rounded rectangle. It contains the following text and fields:

Note:The billing address is equivalent to your Pay To address where your checks will be mailed.
 *Is this billing address the same as the service location?
 Yes No

Billing Location Phone Numbers (Add Billing Location Numbers)

Phone #	Fax #
^Phone #	Fax #^

Billing Location Contact Person(s) (Add Billing Location Contact Person)

Last Name	First Name	Middle Initial	Phone	Ext.	Fax	Position	Email
Last Name^	First Name^	Middle Initial^	Phone^	Ext.^	Fax^	Position^	Email^

Remittance Advice

*Requested Delivery Media for Remittance Advices(RAs)
 Electronic (835) Web Portal Inbox Paper

Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed.

Step	Action
38.	Click the Yes or No option for Billing Address. If No , Complete the new billing address information.
Step	Action
39.	Contact person and email address is required.

Training Guide


Medicaid Provider Enrollment

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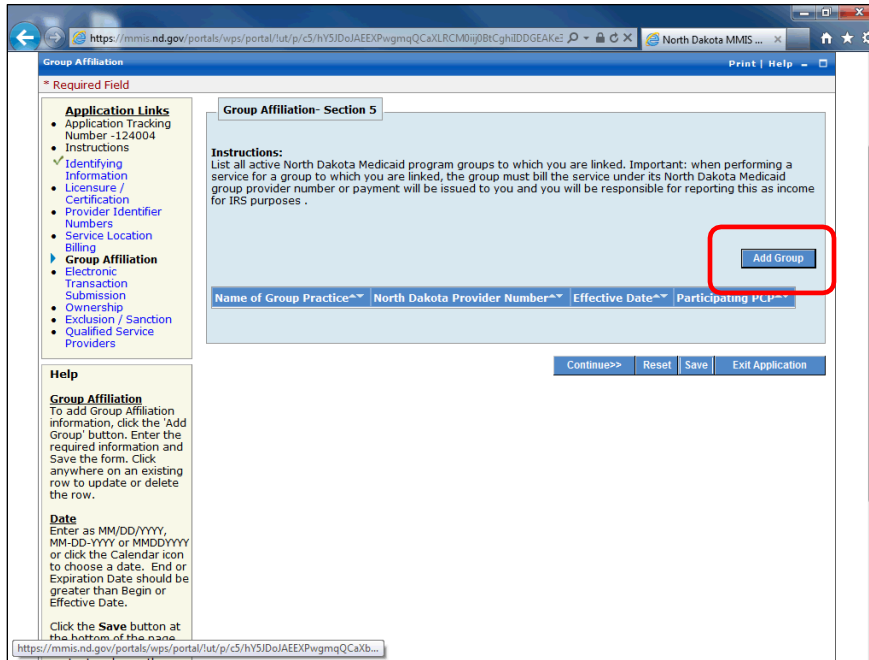
The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/tut/p/c5/nv5jDajAEEpVgmgqQZZiQ1Ito3M04YQUQORYUFQQL>. The page contains several sections:

- Billing Location Phone Numbers:** Includes fields for Phone # and Fax #, with an "Add Billing Location Numbers" button.
- Billing Location Contact Person(s):** Includes fields for Last Name, First Name, Middle Initial, Phone, Ext., Fax, Position, and Email, with an "Add Billing Location Contact Person" button.
- Remittance Advice:** This section is highlighted with a red box. It contains the text: "*Requested Delivery Media for Remittance Advices(RAs)" and three radio button options: "Electronic (835)", "Web Portal Inbox", and "Paper". Below this is a note: "Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed."
- Other Details:** Contains three bullet points:
 - Print Suspend: Choose one of the following options if you would like to include your suspended claims on your Remittance Advice
 - RA Sort Indicator: How would you like your Remittance Advice sorted? If none is chosen, the RA will default to the Members last name
 - Bulletin Media : How would you like to receive your bulletins?
 Below these are three dropdown menus labeled "Print Suspend", "RA Sort Ind", and "Bulletin Media".

At the bottom of the form are buttons for "Continue>>", "Reset", "Save", and "Exit Application". A "Help" section at the bottom left states: "Service Location: Enter the physical address of your primary".

Step	Action
40.	<p>Click the Appropriate RA option. If the individual provider is a rendering provider only, select 'Web Portal Inbox'. The RA option will be driven by the billing provider/group/entity.</p> <p>If the individual is a billing entity under the SSN, then the desired RA should be selected.</p> <ul style="list-style-type: none"> • Electronic 835 – Receive a HIPAA X12 transaction • Web Portal Inbox – Received in the ND MMIS inbox • Paper – Mailed to the billing address listed
Step	Action
41.	<p>Click the Save button.</p> <p></p>
Step	Action
42.	<p>The next section will take you through how to complete the Group Affiliation page.</p> <p>End of Procedure.</p>

Group Affiliation Procedure





Step	Action
1.	<p>If the enrolling individual is affiliated to a group or multiple groups, they must be listed in this section to ensure proper payment. <u>This section is required for all rendering providers.</u></p> <p>*Use the current ND Medicaid group number as the provider number.</p> <p>*Multiple Groups can be added.</p>
Step	Action
2.	<p>Click the Add Group button.</p> <div style="border: 1px solid black; padding: 5px; display: inline-block; background-color: #4a7ebb; color: white; text-align: center; width: 100px; height: 20px; margin-top: 5px;">Add Group</div>

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Step	Action
3.	Enter the desired information into the Name of Group Practice field.
Step	Action
4.	Enter the desired information into the North Dakota Provider Number field. This is the group's current ND Medicaid provider number. This number is seven digits long.
Step	Action
5.	Enter the Effective Date . Enter the effective date of the affiliation.
Step	Action
6.	Click the Save link. 
Step	Action
7.	Click the Save button. 
Step	Action
8.	Click the Continue>> button.

Step	Action
10.	The next section will take you through how to complete the Electronic Transaction Submission page. End of Procedure.

Electronic Transaction Submission

Procedure

In this section, you will need to choose 1 of the 3 options to submit electronic transactions.

- **ND MMIS Web Portal** – for those that will be entering Medicaid claims directly into the ND MMIS web portal. **Rendering providers billing under a group should select ‘North Dakota Web Portal’.** This is the most common scenario.
- **Vendor Software** – for those that have their own software that creates a batch file and are sent directly to the State to process. PC ACE, for example, would be considered vendor software. A provider selecting this option would be acting as their own Trading Partner.
- **Billing Agent/Clearinghouse** – for those that use a third party to submit their claims on behalf of the group. The third party is the Trading Partner.

***Do not enter the group billing information in this section on an individual application.**

***If the individual is the billing entity submitting claims using the SSN and billing through vendor software or a billing agent/clearinghouse, then the appropriate option should be selected.**

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/ut/p/c5/1Y5JDoJAEEXpWgFMFqjxm0RgFIFNgQEIEHmIw6RPh0t>. The page title is "Electronic Transaction Submission".

Required Field

Application Links

- Application Tracking Number - 124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission**
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

Help

Electronic Transaction Submission
 Select one of the submission methods. Additional information will be required if the selection is Vendor Software or Billing Agent/Clearinghouse.

Click the **Save** button at the bottom of the page to validate the page content and save the information.
 Click the **Continue** button to move onto the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print

Electronic Transaction Submission- Section 6

Providers who choose to submit claims, must be aware that payment of claims will be from Federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Further, Providers must understand and agree to do the following:

- Safeguard against abuse in the use of electronic claims submission
- Correctly enter the claims data, monitor the data, and certify that the data entered is correct
- Assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments which might result from carelessness or fraud
- Have on file the applicable documentation to substantiate any claims submitted
- Allow the agency or any of its designees and representatives to review and copy all records, including source documents and data related to information entered through electronic claims submission
- Abide by all Federal and State statutes, rules, regulations, and manuals governing North Dakota programs
- Sign and adhere to all conditions of the Provider Agreement and be officially enrolled in the program to participate in electronic claims submission

Indicate which of the following will be used to submit transactions electronically:


- North Dakota Health Enterprise Portal
- Vendor Software
- Billing Agent/Clearinghouse

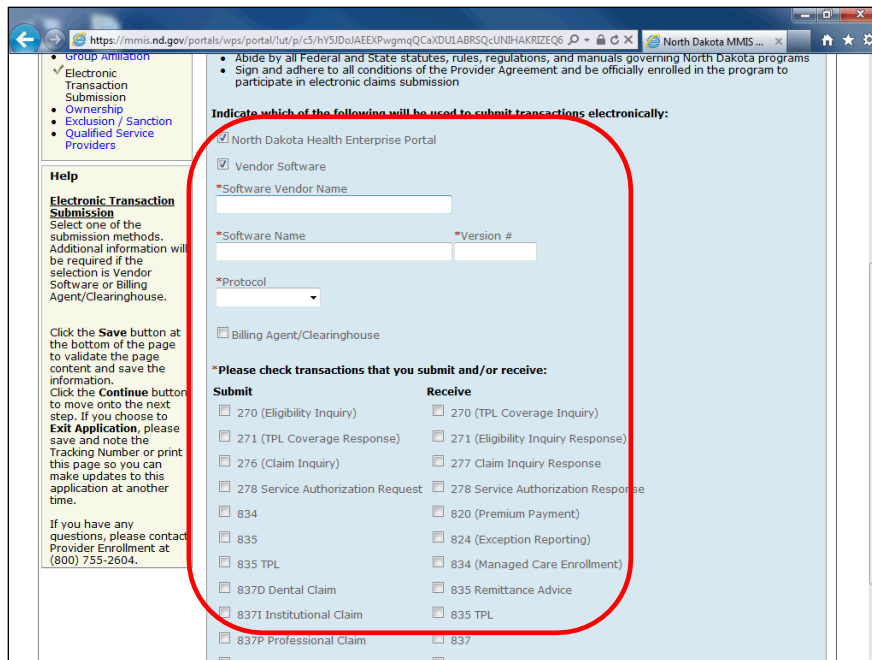
Continue>> **Reset** **Save** **Exit Application**

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
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Step	Action
1.	If using ND MMIS Web Portal, claims can be entered directly into the ND MMIS Web Portal.
Step	Action
2.	Click the ND MMIS Web Portal option. Select this option if the individual is a rendering provider billing under a group.
Step	Action
3.	Click the Save button. 




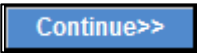
Step	Action
4.	If submission is through a Vendor Software (X12 Transaction), the Provider will be acting as their own Trading Partner.
Step	Action
5.	Click the Vendor Software option.
Step	Action
6.	Enter the desired information into the Software Vendor Name field.

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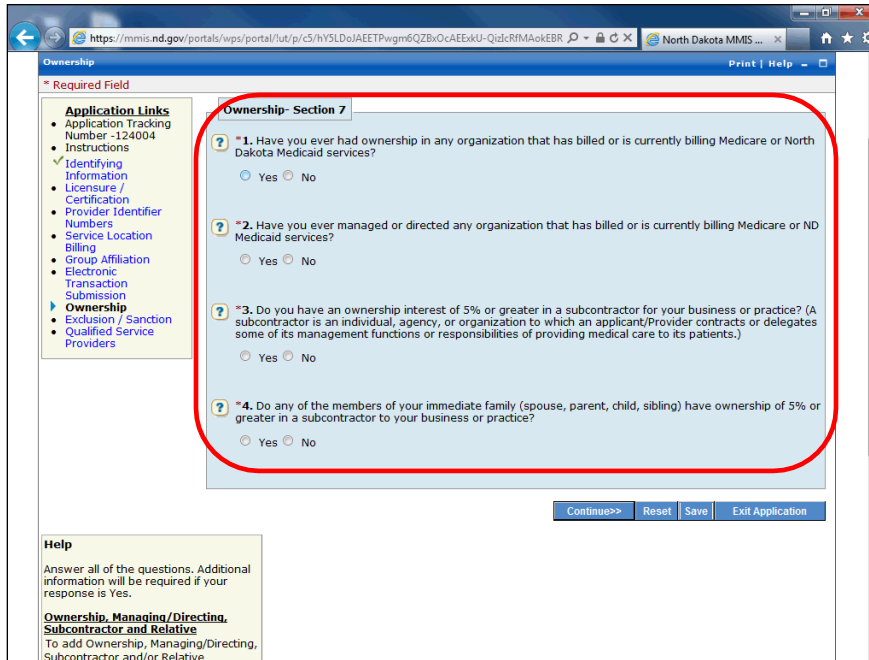
Step	Action
7.	Enter the desired information into the Software Name field.
Step	Action
8.	Enter the desired information into the Version # field.
Step	Action
9.	Click the Protocol list and select the Appropriate list item.
Step	Action
10.	Click the Appropriate Submit and Receive options.
Step	Action
11.	Click the Save button. 

Step	Action
12.	If submission is through a Billing Agent/Clearinghouse, the Agent/Clearinghouse will have to enroll as a trading partner through ND MMIS Web Portal.
Step	Action
13.	Click the Billing Agent/Clearinghouse option.

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Step	Action
14.	Enter the desired information into the Agent/Clearinghouse Name field.
Step	Action
15.	Enter the desired information into the Contact First Name: field.
Step	Action
16.	Enter the desired information into the Contact Last Name: field.
Step	Action
17.	Enter the desired information into the Contact Phone # field.
Step	Action
18.	Enter the desired information into the Street Address field.
Step	Action
19.	Enter the desired information into the City: field.
Step	Action
20.	Enter the desired information into the Zip Code: field.
Step	Action
21.	Click the Appropriate Submit and Receive options.
Step	Action
22.	Click the Save button. 
Step	Action
23.	Click the Continue>> button. 
Step	Action
24.	The next section will take you through how to complete the Ownership page. End of Procedure.

Ownership
Procedure



Step	Action
1.	Click the Yes or No option for questions 1 – 4. If Yes , complete the additional fields. If No , continue to next section.

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The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/tul/p/c5/hy5jDoJAEEpVgmqQCaXSHcwkWSUImBDiANDZfgQ>. The page title is "North Dakota MMIS". The main content area is titled "Add Ownership Information" and contains the following fields and options:

- Organization's Legal Business Name (text input)
- Effective Date (calendar icon)
- End Date (calendar icon)
- Address (text input)
- City (text input)
- State (dropdown menu, currently set to North Dakota)
- Zip (text input)
- EIN Number (text input)
- *Please enter your NPI and/or Medicaid numbers. Indicate Medicare or Medicaid by checking a box below.
 - NPI # (text input)
 - Medicare
 - Medicaid

There are three questions below the form:

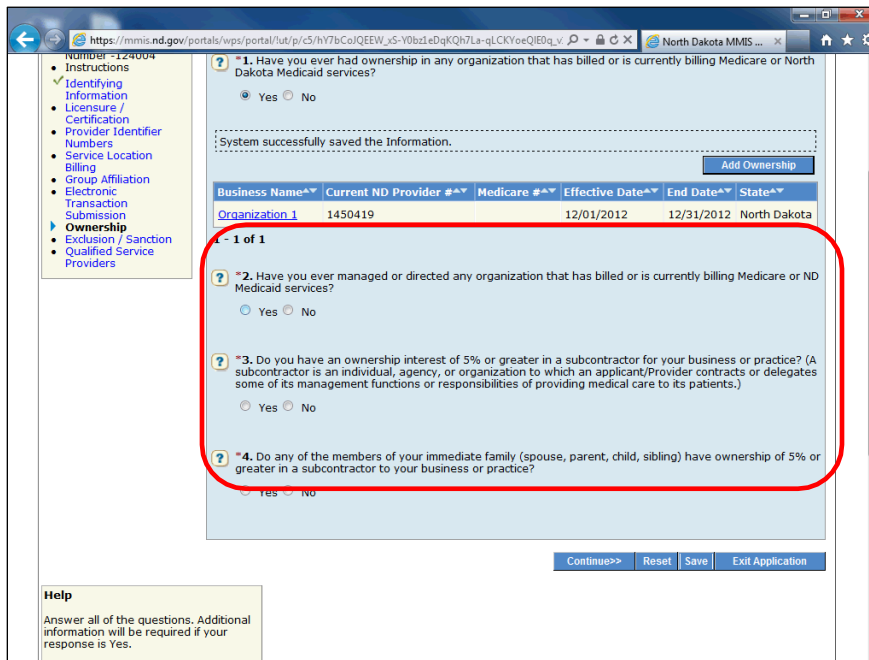
- Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services? (Yes/No radio buttons)
- Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services? (Yes/No radio buttons)
- Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates some of its management functions or responsibilities of providing medical care to its patients.) (Yes/No radio buttons)


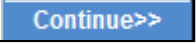
Step	Action
2.	If Yes, Enter the information into the Organization's Legal Business Name field.
Step	Action
3.	Enter the Effective Date and End Date .
Step	Action
4.	Enter the desired information into the Address field.
Step	Action
5.	Enter the desired information into the City field.
Step	Action
6.	Enter the desired information into the Zip field.
Step	Action
7.	Enter the desired information into the EIN Number field.
Step	Action
8.	Enter the desired information into the NPI # field.
Step	Action
9.	Click the Appropriate Medicare or Medicaid option.
Step	Action
10.	Enter the desired information into the Current ND Provider # field.
Step	Action
11.	Click the Save link.

Training Guide

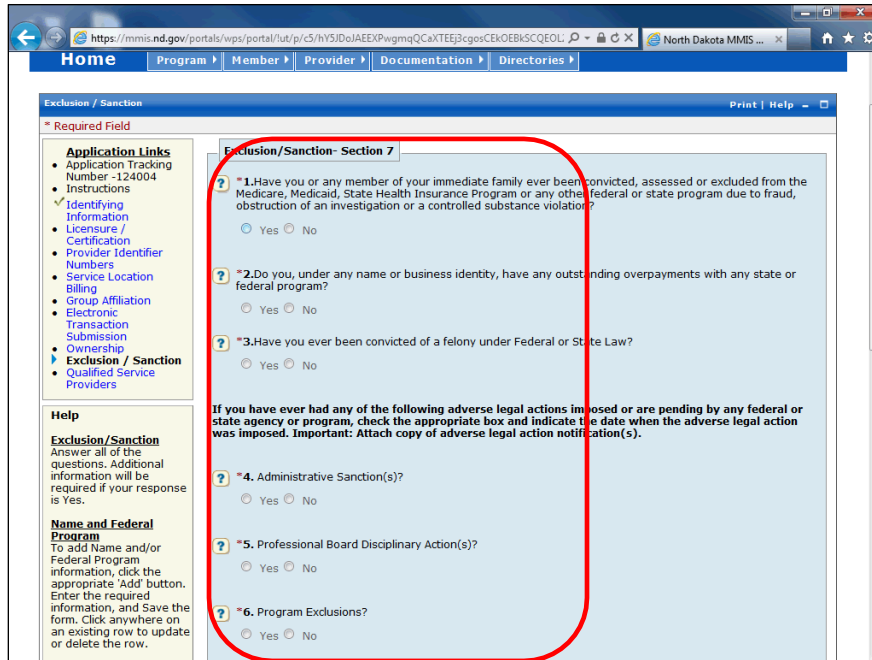
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Step	Action
12.	Repeat the steps for questions 2 – 4. Answering Yes to these questions will require additional information to be completed.
Step	Action
13.	Click the Save button. 
Step	Action
14.	Click the Continue>> button. 
Step	Action
15.	The next section will take you through how to complete the Exclusion / Sanction page. End of Procedure.

Exclusion/Sanction
Procedure


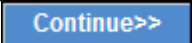


Step	Action
1.	If <u>YES</u> is answered for any question in this section, you will be required to provide additional information.
Step	Action
2.	Click the Yes or No option for questions 1 - 15.

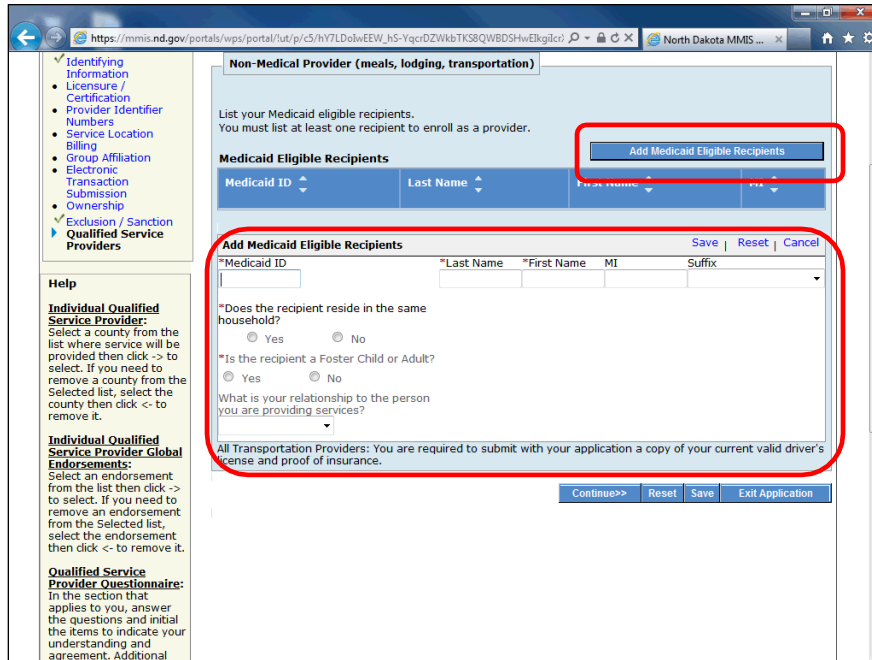
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

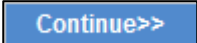
Step	Action
3.	If Yes , complete the additional information.
Step	Action
4.	If No is selected, no further information is needed.
Step	Action
5.	Click the Save button. 
Step	Action
6.	Click the Continue>> button. 
Step	Action
7.	The next section will take you through how to complete the Qualified Service Providers page. End of Procedure.

Qualified Service Providers Procedure

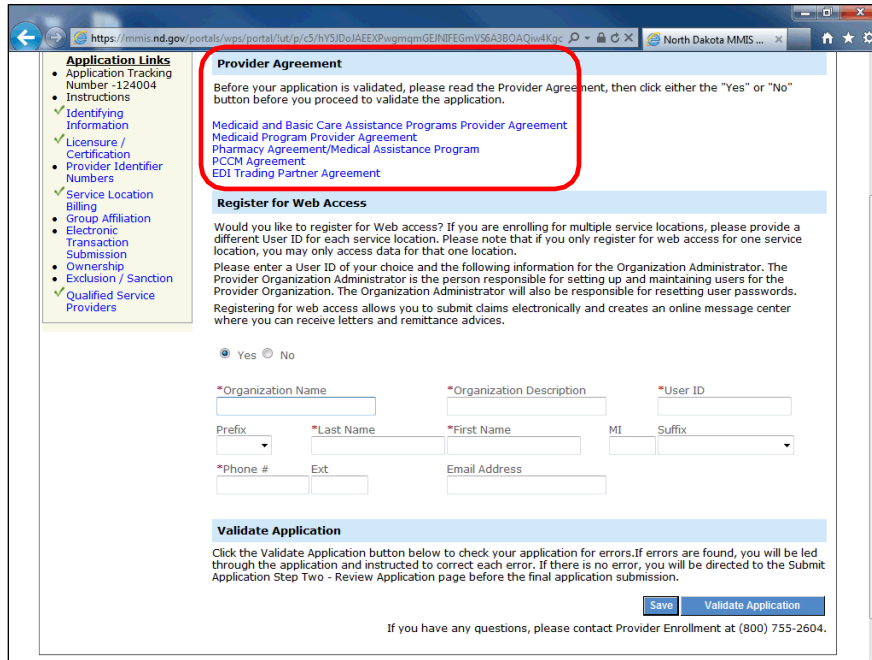


Step	Action
1.	<p>If not enrolling as a Non-Medical Provider (QSP, Transportation, Meals, and Lodging providers), this section can be skipped.</p> <p>If you did not select Qualified Service Provider as a Provider Type or one of the following Specialties:</p> <ol style="list-style-type: none"> 1) Lodging 2) Provide Meals 3) Private Vehicle 4) QSP <p>This Section can be skipped.</p>
Step	Action
2.	<p>Click the Add Medicaid Eligible Recipients button.</p> <div style="border: 1px solid black; padding: 5px; text-align: center; background-color: #4a7ebb; color: white; width: fit-content; margin: 0 auto;"> Add Medicaid Eligible Recipients </div>
Step	Action
3.	Enter the desired information into the Medicaid ID field.
Step	Action
4.	Enter the desired information into the Last Name field.

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Step	Action
5.	Enter the desired information into the First Name field.
Step	Action
6.	Click the Yes or No option.
Step	Action
7.	Click the Yes or No option.
Step	Action
8.	Click the What is your relationship to the person you are providing service list.
Step	Action
9.	Click the Appropriate list item.
Step	Action
10.	Click the Save button. 
Step	Action
11.	Click the Save button. 
Step	Action
12.	Click the Continue>> button. 
Step	Action
13.	The next section will take you through how to complete the Submit Application page. End of Procedure.

Submit Application
Procedure



Step	Action
1.	<p>Read each of the Provider Agreements that pertains to this enrollment.</p> <ul style="list-style-type: none"> • Medicaid Program Provider Agreement is required for <u>all</u> providers. • PCCM Agreement is no longer required. The PCCM Program ended effective 12/31/2023.

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Application Links

- Application Tracking Number - 124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

Provider Agreement

Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.

Medicaid and Basic Care Assistance Programs Provider Agreement
 Medicaid Program Provider Agreement
 Pharmacy Agreement/Medical Assistance Program
 PCCM Agreement
 EDI Trading Partner Agreement

Register for Web Access

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.

Please enter a User ID of your choice and the following information for the Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords.

Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advice.

Yes No

*Organization Name *Organization Description *User ID


Prefix *Last Name *First Name MI Suffix

*Phone # Ext Email Address

Validate Application

Click the Validate Application button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error, you will be directed to the Submit Application Step Two - Review Application page before the final application submission.

If you have any questions, please contact Provider Enrollment at (800) 755-2604.

Step	Action
2.	Registering for Web Access is <u>not recommended for individual rendering providers billing under a group.</u> Individual providers billing independently may choose to register for web access.
Step	Action
3.	Enter the desired information into the Organization Name field.
Step	Action
4.	Enter the desired information into the Organization Description field.
Step	Action
5.	Enter the desired information into the User ID field.
Step	Action
6.	Enter the desired information into the Last Name field.
Step	Action
7.	Enter the desired information into the First Name field.
Step	Action
8.	Enter the desired information into the Phone # field.
Step	Action
9.	Click the Save button. 

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Submit Application Step 1

*** Required Field**
The submitted User ID already exists. Please enter another User ID, or select one of the following suggestions: TOMSMITH, TOMSMITH

Application Links

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

Provider Agreement

Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.

Medicaid and Basic Care Assistance Programs Provider Agreement
Medicaid Program Provider Agreement
Pharmacy Agreement/Medical Assistance Program
PCCM Agreement
EDI Trading Partner Agreement

Register for Web Access

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.

Please enter a User ID of your choice and the following information for the Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords. Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advices.

Yes No

*Organization Name: Smith Clinic
*Organization Description: Clinic
*User ID: [Empty field]

Prefix: [Empty] *Last Name: SMITH *First Name: TOM MI: [Empty] Suffix: [Empty]

*Phone #: 701-555-5555 Ext: [Empty] Email Address: [Empty]

The submitted User ID already exists. Please enter another User ID, or select one of the following suggestions: TOMSMITH, TOMSMITH

Step	Action
10.	If the User ID already exists, you will be prompted to enter a different User ID.

Submit Application Step 1

*** Required Field**
The submitted User ID already exists. Please enter another User ID, or select one of the following suggestions: TOMSMITH, TOMSMITH

Application Links

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

Provider Agreement

Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.

Medicaid and Basic Care Assistance Programs Provider Agreement
Medicaid Program Provider Agreement
Pharmacy Agreement/Medical Assistance Program
PCCM Agreement
EDI Trading Partner Agreement

Register for Web Access

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.

Please enter a User ID of your choice and the following information for the Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords. Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advices.

Yes No

*Organization Name: Smith Clinic
*Organization Description: Clinic
*User ID: TOMSMITH

Prefix: [Empty] *Last Name: SMITH *First Name: TOM MI: [Empty] Suffix: [Empty]

*Phone #: 701-555-5555 Ext: [Empty] Email Address: [Empty]

Validate Application

Click the Validate Application button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error, you will be directed to the Submit Application Step Two - Review Application page before the final application submission.

Validate Application

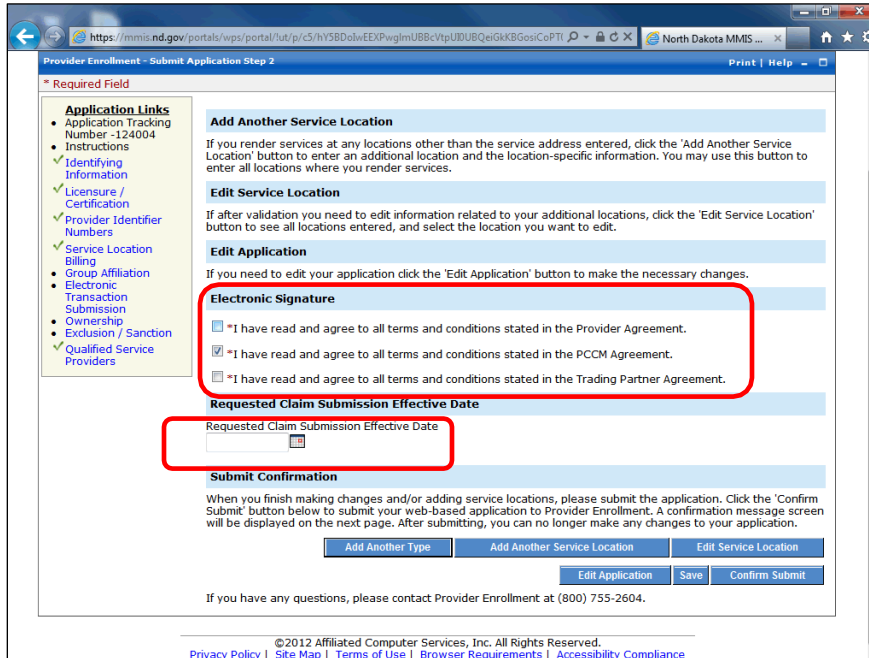
If you have any questions, please contact Provider Enrollment at (701) 785-2604

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Step	Action
11.	Click the Validate Application button. This will check the application for errors. <div style="text-align: center; border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">Validate Application</div>

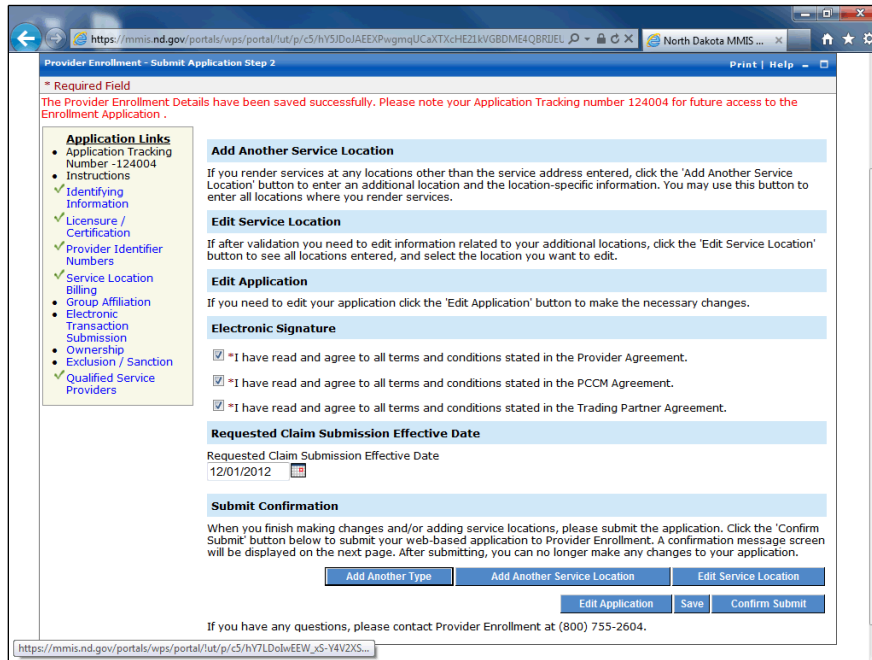


Step	Action
12.	Click the required Electronic Signature options.
Step	Action
13.	Enter the Requested Claim Submission Effective Date .
Step	Action
14.	Click the Save button. <div style="text-align: center; border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">Save</div>

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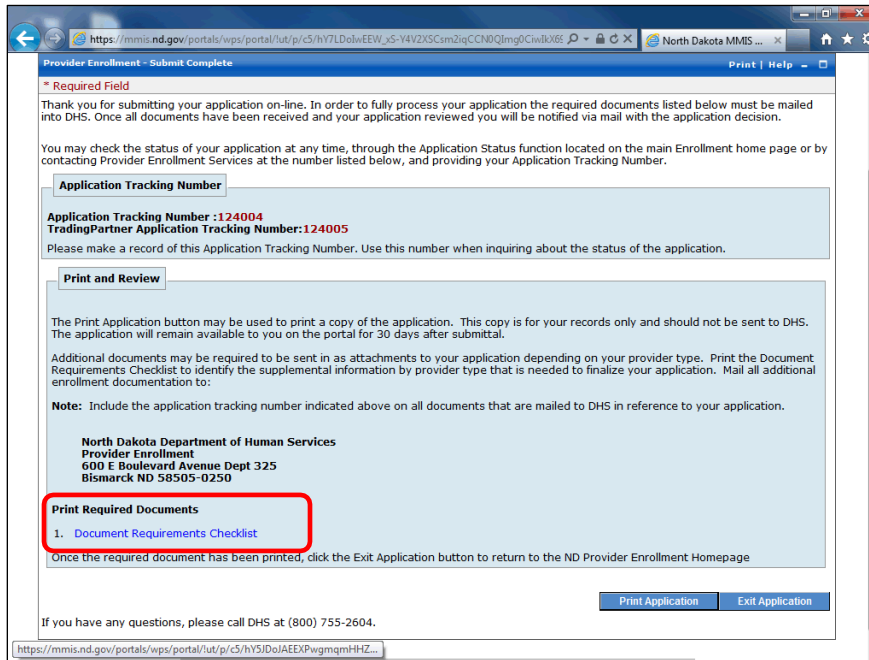


Step	Action
15.	<u>Review the application for accuracy and completeness before submitting the application.</u>
Step	Action
16.	Add Another Type and Add Another Service Location should <u>never</u> be used on an individual application. If the individual has more than one provider type, then a separate application is required. If the individual practices at multiple locations, then use the group affiliations page to associate all locations.
Step	Action
17.	If you click the Confirm Submit option, you will not be able to make any further edits to the application.
Step	Action
18.	Click the Confirm Submit button if you have no edits or updates to make to the application. <div style="text-align: center; border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Confirm Submit </div>

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Step	Action
19.	Click Document Requirements Checklist to determine what Documents need to be sent to the Department of Human Services. **The above screen needs to be printed and mailed with the required documents to ensure there is a reference to the Application Tracking Number (ATN).
Step	Action
20.	Click the Print Application button if you would like to keep a copy for your own records . Do not submit a printed application with your required documents. Print Application

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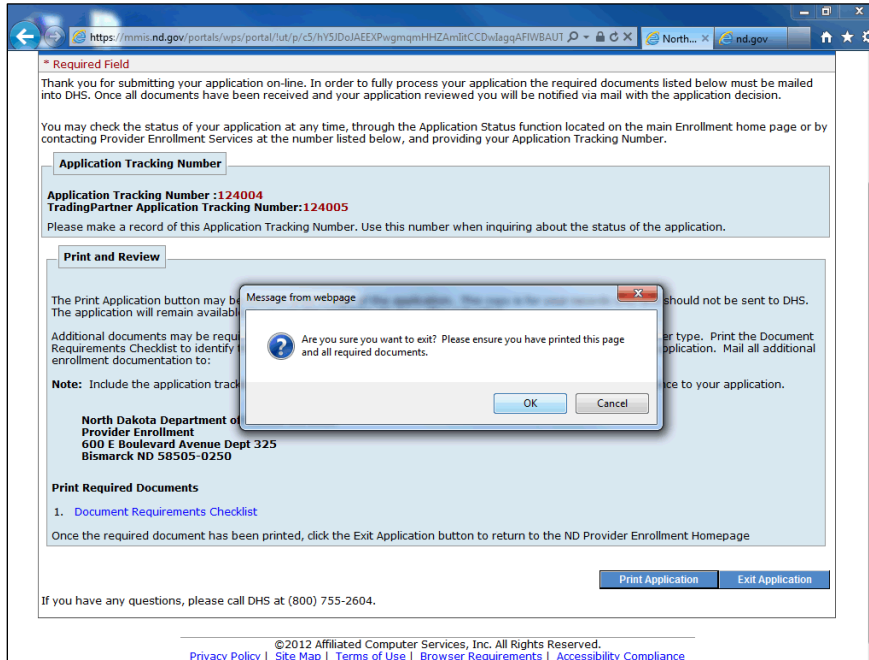
Step	Action
21.	Print a copy of the application for your own records. <u>Do not</u> submit a printed copy with the required documents.

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Step	Action
22.	Click the Exit Application button. <div style="border: 1px solid black; padding: 2px; display: inline-block; background-color: #4F81BD; color: white; text-align: center; width: 150px; height: 20px; margin-top: 5px;">Exit Application</div>



Step	Action
23.	Click the OK button. <div style="border: 1px solid black; padding: 2px; display: inline-block; background-color: #4F81BD; color: white; text-align: center; width: 100px; height: 20px; margin-top: 5px;">OK</div>
Step	Action
24.	End of Procedure.