

# North Dakota Medicaid Targeted Case Management Application Checklists & Attestations

You must fill out the checklist for your application entirely and attach the documents indicated on the checklist along with signed signature pages for the packet to be considered complete.

The department does not retain incomplete documents. If this packet is incomplete when it is received, the entire packet will be deleted and you will receive an email notification at the contact email address entered on the checklist.



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# North Dakota Department of Human Services Targeted Case Management Application Checklists & Attestations

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# TCM Child Welfare Individual Practitioner Application - Formset

**New Application**

**Reactivation**

Have Questions?  
[Click Here](#) for FAQs and More Resources

Application Tracking #					
Practitioner Name					
<a href="#">Individual NPI #</a>					
Primary Service Address	Street				
	City		State		Zip
Facility Mailing Address	Street				
	City		State		Zip

Who will be billing for this individual provider's services?

**Enrolled Billing Group (Affiliation)**

Medicaid ID		Billing Group Name		Facility Phone	
Medicaid ID		Billing Group Name		Facility Phone	

**Unenrolled Billing Group. Please Provide Application Tracking Number and/or NPI:**

**No Billing Group - Practitioner is enrolling as an Ordering or Referring provider only and will not have affiliations with a billing group. Check this option only if claims will not be submitted for services rendered by this practitioner – only enrolling to order, refer, or prescribe.**

Contact Name					
Contact Phone		Ext			
Contact Email					
Who is filling out this form?	Name		Date form was completed		

<b>PROVIDER TYPE</b>	017-Other Service Providers
<b>SPECIALTY</b>	335-Case Manager/Care Coordinator
<b>TAXONOMY</b>	171M00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

[Click Here to find more information on Effective Dates and Retro Effective Date Policies](#)

**What is the Enrollment Effective Date you are requesting?**

\*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. **You must include a copy of the claim and medical notes with your application documents.**

A Copy of the Claim/Claims is attached to my documents.

A Copy of the Medical Notes is attached to my documents.

Required Documents				Submitted
<a href="#">Fax/Email Coversheet</a>				
This Formset				
Degree*	Field:		Issued:	
Wraparound Certificate**	Issued:		Expires:	
Printout of Individual NPI from the <a href="#">NPPES Website</a>		Enumeration Date		
<a href="#">SFN 615 (6-2023)</a>	Page 4 of the SFN 615 form must be signed & dated by the Individual Provider who is applying.			

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

<b>*Degree must be Bachelor's or above and be in one of the following fields:</b>		
1. Social Work	6. Elementary Education	10. Human Resource Management (human-service track)
2. Psychology	7. Early Childhood Education	11. Criminal Justice
3. Sociology	8. Special Education	12. Human Services - Child & Family Welfare
4. Counseling	9. Child Development and Family Science	
5. Human Development		

\*\*If enrolling before Wraparound Certificate is issued, Wraparound Certificate must be obtained and submitted within 12 months.

# TCM High Risk Pregnant Women & Infants Individual Practitioner Application - Formset

**New Application**

**Reactivation**

Have Questions?  
[Click Here](#) for FAQs and More Resources

Application Tracking #					
Practitioner Name					
<a href="#">Individual NPI #</a>					
Primary Service Location	Street				
	City		State		Zip
Facility Mailing Address	Street				
	City		State		Zip

Who will be billing for this individual provider's services?

**Enrolled Billing Group (Affiliation)**

Medicaid ID		Billing Group Name		Facility Phone	
Medicaid ID		Billing Group Name		Facility Phone	

**Unenrolled Billing Group. Please Provide Application Tracking Number and/or NPI:**

**No Billing Group - Practitioner is enrolling as an Ordering or Referring provider only and will not have affiliations with a billing group. Check this option only if claims will not be submitted for services rendered by this practitioner – only enrolling to order, refer, or prescribe.**

Contact Name				
Contact Phone		Ext		
Contact Email				
Who is filling out this form?	Name		Date form was completed	

<b>PROVIDER TYPE</b>	017-Other Service Providers
<b>SPECIALTY</b>	335-Case Manager/Care Coordinator
<b>TAXONOMY</b>	171M00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

[Click Here to find more information on Effective Dates and Retro Effective Date Policies](#)

What is the Enrollment Effective Date you are requesting?

\*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. **You must include a copy of the claim and medical notes with your application documents.**

A Copy of the Claim/Claims is attached to my documents.

A Copy of the Medical Notes is attached to my documents.

Required Documents				Submitted
<a href="#">Fax/Email Coversheet</a>				
This Formset				
Degree*	Field:		Issued:	
<a href="#">Individual Attestation*</a>	Requirements Completed On:			
License*		Issued:	Expires:	
Printout of Individual NPI from the <a href="#">NPPES Website</a>		Enumeration Date		
<a href="#">SFN 615 (6-2023)</a>	Page 4 of the SFN 615 form must be signed & dated by the Individual Provider who is applying.			

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

\*May Enroll under any of the criteria below.

Enrollment Criteria
<ol style="list-style-type: none"> <li>1. Social Work Master's Degree</li> <li>2. Social Work License + Attestation (Option #1 checked)</li> <li>3. RN License</li> <li>4. LPN License + Attestation (Option #1 checked)</li> <li>5. Bachelor's Degree + Attestation (Option # 2 checked - health educator)</li> <li>6. Licensed Registered Dietitian License or Licensed Nutritionist License</li> <li>7. Attestation (Option #3 checked)</li> </ol>

Revision 8/2/2023

**INDIVIDUAL ATTESTATION**  
**TARGETED CASE MANAGEMENT SERVICES TO HIGH RISK**  
**PREGNANT WOMEN AND INFANTS**

\_\_\_\_\_  
Practitioner Name (printed)

\_\_\_\_\_  
NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

**I have met the following requirement:**

(CHECK ALL THAT APPLY):

1. \_\_\_\_\_ I have at least six months of case management experience.

OR

2. \_\_\_\_\_ I am qualified to practice as a Health Educator and have at least six months of case management experience.

OR

3. \_\_\_\_\_ I have at least five years of experience working with high risk pregnant women in a supervised, clinical setting.

I attest that I met the above requirement on \_\_\_\_\_ (Month/Day/Year).



\_\_\_\_\_  
Signature of Enrolling Practitioner



\_\_\_\_\_  
Date

**Provider Facility/Organization to complete:**

I attest that the practitioner mentioned above has met the established criteria as indicated above.

\_\_\_\_\_  
Provider Facility/Organization Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code



\_\_\_\_\_  
Supervisor Signature



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Supervisor

**Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956, ATT: NDM Provider Enrollment**

# TCM Long Term Care Individual Practitioner Application - Formset

**New Application**

**Reactivation**

Have Questions?  
[Click Here](#) for FAQs and More Resources

Application Tracking #					
Practitioner Name					
<a href="#">Individual NPI #</a>					
Primary Service Address	Street				
	City		State		Zip
Facility Mailing Address	Street				
	City		State		Zip

Who will be billing for this individual provider's services?

**Enrolled Billing Group (Affiliation)**

Medicaid ID		Billing Group Name		Facility Phone	
Medicaid ID		Billing Group Name		Facility Phone	

**Unenrolled Billing Group. Please Provide Application Tracking Number and/or NPI:**

**No Billing Group - Practitioner is enrolling as an Ordering or Referring provider only and will not have affiliations with a billing group. Check this option only if claims will not be submitted for services rendered by this practitioner – only enrolling to order, refer, or prescribe.**

Contact Name				
Contact Phone		Ext		
Contact Email				
Who is filling out this form?	Name		Date form was completed	

<b>PROVIDER TYPE</b>	017-Other Service Providers
<b>SPECIALTY</b>	335-Case Manager/Care Coordinator
<b>TAXONOMY</b>	171M00000X



Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

[Click Here to find more information on Effective Dates and Retro Effective Date Policies](#)

What is the Enrollment Effective Date you are requesting?

\*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. **You must include a copy of the claim and medical notes with your application documents.**

A Copy of the Claim/Claims is attached to my documents.

A Copy of the Medical Notes is attached to my documents.

Required Documents			Submitted
<a href="#">Fax/Email Coversheet</a>			
This Formset			
<a href="#">Individual LTC Attestation</a>	Requirements Completed On:		
Social Work License*	Issued:	Expires:	
Printout of Individual NPI from the <a href="#">NPPE Website</a>	Enumeration Date		
<a href="#">SFN 615 (6-2023)</a>	Page 4 of the SFN 615 form must be signed & dated by the Individual Provider who is applying.		

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

\*Social Work License is not required if provider can attest to the requirements on the TCM Long Term Care Practitioner's Attestation and submits the completed Attestation.

\*Social Work License submitted must be current as of the date the application is approved.

Revision 8/2/2023

# INDIVIDUAL ATTESTATION

## LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

\_\_\_\_\_  
Practitioner Name (printed)

\_\_\_\_\_  
NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

**I have met the following requirements:**

(CHECK ALL THAT APPLY):

1. \_\_\_\_\_ I am a Developmental Disabilities program manager  
AND

a. \_\_\_\_\_ I am a Qualified Intellectual Disabilities Professional (QIDP)

OR

b. \_\_\_\_\_ I have at least 1 year of experience as a Developmental Disabilities Case Manger in the North Dakota Department of Human Services.

I attest that I met the above requirements on \_\_\_\_\_ (Month/Day/Year).



\_\_\_\_\_  
Signature of Enrolling Practitioner



\_\_\_\_\_  
Date

---

### Provider Facility/Organization to complete:

I attest that the practitioner mentioned above has met the established criteria as indicated above.

\_\_\_\_\_  
Provider Facility/Organization Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code



\_\_\_\_\_  
Supervisor Signature



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Supervisor

Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956, ATT: NDM Provider Enrollment

# TCM SMI/SED Individual Application Checklist

**New Application**

**Reactivation**

Have Questions?  
[Click Here](#) for FAQs and More Resources

Application Tracking #					
Practitioner Name					
<a href="#">Individual NPI #</a>					
Primary Service Location	Street				
	City		State		Zip
Facility Mailing Address	Street				
	City		State		Zip

**Who will be billing for this individual provider's services?**

**Enrolled Billing Group (Affiliation)**

Medicaid ID		Billing Group Name		Facility Phone	
Medicaid ID		Billing Group Name		Facility Phone	

**Unenrolled Billing Group. Please Provide Application Tracking Number and/or NPI:**

**No Billing Group - Practitioner is enrolling as an Ordering or Referring provider only and will not have affiliations with a billing group. Check this option only if claims will not be submitted for services rendered by this practitioner – only enrolling to order, refer, or prescribe.**

Contact Name				
Contact Phone		Ext		
Contact Email				
Who is filling out this form?	Name		Date form was completed	

<b>PROVIDER TYPE</b>	017-Other Service Providers
<b>SPECIALTY</b>	335-Case Manager/Care Coordinator
<b>TAXONOMY</b>	171M00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

[Click Here to find more information on Effective Dates and Retro Effective Date Policies](#)

What is the Enrollment Effective Date you are requesting?

\*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. **You must include a copy of the claim and medical notes with your application documents.**

A Copy of the Claim/Claims is attached to my documents.

A Copy of the Medical Notes is attached to my documents.

Required Documents				Submitted
<a href="#">Fax/Email Coversheet</a>				
This Formset				
Individual SMI/SED Attestation*	Requirements Met On:			
Printout of Individual NPI from the <a href="#">NPPES Website</a>		Enumeration Date		
<a href="#">SFN 615 (6-2023)</a>	Page 4 of the SFN 615 form must be signed & dated by the Individual Provider who is applying.			

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

**\*Degree must be in one of the following fields:**

- |                      |  |   |
|----------------------|--|---|
| 1. Social Work       | 6. Special Education                               | 11. Communication Science/Disorders   |
| 2. Psychology        | 7. Child Development and Family Science            | 12. Vocational Rehabilitation   |
| 3. Nursing           | 8. Human Resource Management (human-service track) | 13. Human Services - Child & Family Welfare                                     |
| 4. Sociology         | 9. Criminal Justice                                | 14. Addiction Studies (Requires Transcripts unless from Minot State University) |
| 5. Counseling        | 10. Occupational Therapy                           | 15. Addiction Counseling  |
| 6. Human Development |  |   |

Revision 8/2/2023

# INDIVIDUAL ATTESTATION

TARGETED CASE MANAGEMENT SERVICES  
SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS EMOTIONAL DISTURBANCE (SED)

\_\_\_\_\_  
Practitioner Name (printed)

\_\_\_\_\_  
NPI

Please fill out this form to confirm required training or background requirements for enrollment as a Targeted Case Management individual provider (practitioner). Requirements are per Medical Services Division policies or Medicaid State Plan requirements.

**I meet the following requirements:** CHECK ALL THAT APPLY

Have a bachelor's degree AND two years of experience working with special population groups<sup>1</sup> in a direct care setting,

a. Please list special population group or groups you have worked with:

\_\_\_\_\_, OR

Have a master's degree, OR

Have at least five years of experience working with individuals with SMI/SED in a supervised, clinical setting.

I attest that I met the above requirement on \_\_\_\_\_ (Month/Day/Year)



\_\_\_\_\_  
Signature of Enrolling Practitioner

\_\_\_\_\_  
Date

## Provider Facility/Organization to complete:

I attest that the practitioner mentioned above has met the established criteria as indicated above.

\_\_\_\_\_  
Provider Facility/Organization Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code



\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Supervisor

**Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956**

<sup>1</sup>Special population groups include nursing home or assisted living residents, youth in psychiatric treatment centers or residential facilities, individuals in substance use treatment facilities, individuals in mental health/substance use facilities, and experience working in hospitals with youth and/or adults with serious mental illness or serious emotional disturbance. This list is not exhaustive.

# Group Application Checklist

## Targeted Case Management Group (025 - 035)

Type of TCM Services provided (Check all you are enrolling to provide): Child

Welfare

Long Term Care

SMI/SED

High Risk Pregnant Women & Infants

Have Questions?  
[Click Here](#) for FAQs and More Resources

**All 4 Sections and Fields are Required unless specifically marked as not required**

<b>Section 1: Identifying Information</b>	Application Tracking #	
	Provider Name	
	<a href="#">Organizational NPI #</a>	
	Service Address	
	Billing Address	
	Mailing Address	
	Facility Phone	
	Contact Person	
	Phone	
	Email	

<b>Section 2: Questions</b>	1. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?)		YES	NO	
	2. Are you enrolling any additional service locations not listed above at this time? If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address). <i>Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.</i>		YES	NO	
	3. Are you exempt from FEDERAL taxes?		YES	NO	If Exempt from <b>FEDERAL</b> Taxes, submit your <b>IRS</b> issued Tax Exempt Letter.
	4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect)		YES	NO	
	5. How many Managing Employees (authorized to sign on behalf of the business) do you have? If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2). List must contain First Names, Last Names, Dates of Birth, and SSNs				
	6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?		YES	NO	
	6a. If Yes, how many Board Members do you have? If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).				

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	<b>Enter Initials below (required for enrollment)</b>
---	---

Section 3: Required Documents	The documents requested below must be returned to the Department in order to process your enrollment		
	Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links
	1. <a href="#">Coversheet for Fax/Email</a>		<a href="#">Coversheet for Fax/Email</a>
	2. Group Application Checklist		
	3. List of Service Locations (Required if you answered Yes to question 2 above)		
	4. <a href="#">W-9 (10-2018)</a>	Printed Name of Signing Managing Employee:	<a href="#">W-9 (10-2018)</a>
	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		<a href="#">What is the CP575/147C?</a>
	6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from <b>FEDERAL</b> Taxes, submit your <b>IRS</b> issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the <b>IRS</b> .		<a href="#">IRS Tax Exempt Letter for Government Agencies</a>
	7. Group Attestation for each TCM Service you are enrolling to provide. Attestation submitted must match the TCM services checked at the top of this checklist. If enrolling to provide more than one type of service, please submit the attestation for each service.	<a href="#">Child Welfare</a> <a href="#">High Risk Pregnant Women &amp; Infants</a>	<a href="#">Long Term Care</a> <a href="#">SMI/SED</a>
	8. NPI prinout from the <a href="#">NPPES Website</a>		<a href="#">NPPES Website</a>
	9. <a href="#">SFN 661 (12-2022)</a>	Printed Name of Signing Managing Employee:	<a href="#">SFN 661 (12-2022)</a>

9a. Bank Letter/Voided Check      Must match the Information provided on the SFN 661

11. <a href="#">SFN 1168 (8-2020)</a>		<a href="#">Simplified Instructions based on FAQs</a>
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		

12. <a href="#">SFN 615 (6-2023)</a>	Printed Name of Signing Managing Employee:	<a href="#">SFN 615 (1-2022)</a>
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Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date	<b>PROVIDER TYPE</b> Either 025-Agencies or 047-Indian Health Services/638 Tribal
	<b>SPECIALTY</b> 035-Case Management
	<b>TAXONOMY</b> 251B00000X
	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the application is approved</b> and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a <b>complete</b> application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.
	*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. <b>You must include a copy of the claim and medical records with your application documents.</b>
	<input type="checkbox"/> This application is associated with an emergency service. We are requesting the date of _____. Refer to the * above.

Requested Enrollment Effective Date	
-------------------------------------	--

Printed Name of Person Requesting the Effective Date		Date	
--	--	------	--

[Click Here to find more information on Effective Dates and Retro Effective Date Policies](#)

**GROUP PROVIDER ATTESTATION**  
**TARGETED CASE MANAGEMENT SERVICES**  
**CHILD WELFARE**

\_\_\_\_\_  
Provider Name (printed)

\_\_\_\_\_  
NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

**This group provider has met all the following requirements:**

(CHECK ALL THAT APPLY):

1. \_\_\_\_\_ Has in place a training process that will ensure that staff have adequate knowledge relating to children involved in unsafe, crisis, and/or unstable situations.
2. \_\_\_\_\_ Has the ability to be available 24 hours, 7 days a week to eligible clients who are in need of emergency case management services.
3. \_\_\_\_\_ All Supervisors of case management staff have a minimum of a bachelor's degree in social work, psychology, sociology, counseling, human development, elementary education, early childhood education, special education, child development and family science, human resource management (human service track), or criminal justice.
4. \_\_\_\_\_ All Supervisors of case management staff have successfully completed the Department of Human Services approved Wraparound Certification training, or are in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management.
5. \_\_\_\_\_ All Supervisors of case management staff shall maintain Wraparound Certification status through attending a Department of Human Services approved Wraparound Recertification training at least once every two years.

I attest that this provider met the above requirements on \_\_\_\_\_  
(Month/Day/Year).

\_\_\_\_\_  
Provider Facility/Organization Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code



\_\_\_\_\_  
Signature of Authorized Representative



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Authorized Representative

**Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956, ATT: NDM Provider Enrollment**



**GROUP PROVIDER ATTESTATION**  
**TARGETED CASE MANAGEMENT SERVICES**  
**LONG TERM CARE**

\_\_\_\_\_  
Provider Name (printed)

\_\_\_\_\_  
NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

**This group provider has met the following requirement:**

1. \_\_\_\_\_ Has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled persons.

I attest that this provider met the above requirement on \_\_\_\_\_  
(Month/Day/Year).

\_\_\_\_\_  
Provider Facility/Organization Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code



\_\_\_\_\_  
Signature of Authorized Representative



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Authorized Representative

**Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956, ATT: NDM Provider Enrollment**

**GROUP PROVIDER ATTESTATION**  
**TARGETED CASE MANAGEMENT SERVICES**  
**HIGH RISK PREGNANT WOMEN AND INFANTS**

\_\_\_\_\_  
Provider Name (printed)

\_\_\_\_\_  
NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

**This group has met all the following requirements:**

(CHECK ALL THAT APPLY):

1. \_\_\_\_\_ Has at least six months experience in delivering services in a community or home setting.
2. \_\_\_\_\_ Has the ability to coordinate prenatal care services for individuals, develop relationships with health care and other area agencies in the particular geographical area they are serving, demonstrate experience in assessing the needs of pregnant women and developing case management plans based on the needs of clients and must demonstrate the ability to evaluate an at risk pregnant woman's progress in obtaining appropriate medical care and other needed services.
3. \_\_\_\_\_ All case management staff supervisors have a minimum of a degree in social work, nursing, education, and have at least three years experience in service delivery and supervision.
4. \_\_\_\_\_ Has in place a training process that will ensure that staff have adequate knowledge relating to high-risk pregnancy, parenting and other important issues.
5. \_\_\_\_\_ Has the ability to provide 24 hour, 7 day a week crisis services to eligible women who are in need of emergency case management services.
6. \_\_\_\_\_ Has at least one practitioner who possesses the appropriate training or background as required by the Targeted Case Management State Plan.

I attest that this provider met the above requirements on \_\_\_\_\_  
(Month/Day/Year).

\_\_\_\_\_  
Provider Facility/Organization Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code



\_\_\_\_\_  
Signature of Authorized Representative



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Authorized Representative

**Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956, ATT: NDM Provider Enrollment**

# GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES  
SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS EMOTIONAL DISTURBANCE (SED)

\_\_\_\_\_  
**Provider Name (printed)**

\_\_\_\_\_  
**NPI**

Please fill out this form to confirm required training or background requirements for enrollment as a Targeted Case Management provider. Requirements are per Medical Services Division policies or Medicaid State Plan requirements.

This group provider meets all the following requirements (#6 is needed if the group provider is a North Dakota federally recognized Indian Tribe or Indian Tribal Organization): CHECK ALL THAT APPLY

1. This provider can be available 24 hours, 7 days a week to individuals who need emergency case management services.
2. All Supervisors of case management staff have a bachelor's degree.
3. All individuals providing targeted case management have reviewed the competencies or standards of practice in one of the following:
  - a. The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care:  
- [SAMHSA Core Competencies for Integrated Care](#)
  - OR
  - b. The Case Management Society of America standards of practice.  
- [Case Management Society Standards of Practice](#)
4. All individuals providing case management have general knowledge, training and/or experience working with individuals with SMI and/or SED.
5. All Individuals providing case management will either:
  - a. Have a master's degree, OR
  - b. Have a bachelor's degree AND two years of experience working with special population groups<sup>2</sup> in a direct care setting; OR
  - c. Have at least five years of experience working with individuals with SMI/SED in a supervised, clinical setting.
6. All Individuals providing case management who are employed by North Dakota federally recognized Indian Tribe or Indian Tribal Organizations will possess the necessary cultural sensitivity and background knowledge to provide appropriate services to the Native American population served.

I attest that this provider met the above requirements on \_\_\_\_\_ (Month/Day/Year)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Facility/Organization Name

Street Address

City, State, Zip Code



\_\_\_\_\_  
Signature of Authorized Representative



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Authorized Representative

Please sign and return by Email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956

<sup>2</sup> Special population groups include nursing home or assisted living residents, youth in psychiatric treatment centers or residential facilities, individuals in substance use treatment facilities, individuals in mental health/substance use facilities, and experience working in hospitals with youth and/or adults with serious mental illness or serious emotional disturbance. This list is not exhaustive.

# FAQs and Resources

## Am I Already Enrolled?

[Click Here](#) to find out. Search by your NPI.

## What is North Dakota Medicaid's Application Process?

[Process for Individual Applications](#)

[Process for Group Applications](#)

## I am a Sole Proprietor, Would I complete an Individual or Group Application?

It depends on how you want to enroll with ND Medicaid. [Click Here](#) for more details.

## What Documents are Actually Required?

All documents listed on the application checklist are required. If a document is not required for all providers, it is noted specifically as not required next to the document name in the checklist. Additionally, all fields in all Sections on the checklist must be completed.

## What is an Application Tracking Number (ATN)?

An Application Tracking Number (or "ATN" for short) is the 6 digit number assigned by the system once the online portion of the application is submitted in the Web Portal. The ATN may be assigned by the system after clicking save in the application, even before it is submitted. The ATN assigned to your application will show on the top left of each page of the online application when you click "Save" at the bottom of the screen.

## What is an NPI?

[Click Here](#) to find more information about NPIs.

## What is a North Dakota Medicaid ID?

The North Dakota Medicaid ID is a unique identifier the system assigns to each application once it reaches the "Approved Status". It is 7 digits and replaces your Application Tracking Number. Once assigned a 7 digit Medicaid ID, please include the ID in every correspondence with the Department regarding that record.

*Please Note: If you were enrolled in our old system (prior to 2013 - often called "Legacy", please do not use your previous Medicaid ID. The Legacy numbers had place holding zeros and 4-5 numbers at the end. Legacy numbers have been replaced by the new 7 digit numbers as your Medicaid ID. Use of the Legacy numbers on documents may delay your update requests.*

## What is an Enrollment Effective Date?

[Click Here](#) to find more information about Enrollment Effective Dates and current back dating policies.

## **Am I required to use the Provider Enrollment Fax/Email Coversheet or can I use my own?**

A coversheet must be submitted with all documents sent to the Department in order to identify the purpose of the documents. The Provider Enrollment Fax/Email coversheet is not required, as long as your coversheet has the following elements: 1. Provider Name; 2. NPI; 3. Medicaid ID or Application Tracking Number; 4. Name of the person in your organization who should be contacted if there are any questions about the documents submitted; 5. Phone number for the contact; 6. Email address for the contact; 7. Purpose you submitted the documents (application, revalidation, affiliation etc.). A sample list of reasons for document submission can be found on the Provider Enrollment Fax/Email Coversheet for reference.

## **Whose NPI and Medicaid ID goes on the SFN 615?**

The NPI and Medicaid ID of the enrolling individual go on the SFN 615. As this is an individual application, do not put the Medicaid ID or NPI of the billing group.

## **Is an Attestation Required?**

A Group Level Attestation is required at enrollment and revalidation of the billing group's record.

If not received at enrollment or revalidation of the billing group, it is required with the individual application or affiliation of a new type of TCM provider to that group.

Once the attestation for that type of TCM service is on file, you are not required to submit a new Group Attestation for that type of TCM service until the record is due for reactivation (or if the record has been terminated and is being reactivated).

An Individual (Practitioner) Level Attestation is required at enrollment and revalidation of the Individual Practitioner's record - when the checklist states it is required.

## **Which Attestation is Required?**

A Group Attestation must be on file for each group which provides the following TCM services:

1. Child Welfare.
2. High Risk Pregnant Women and Infants (General Population)
3. High Risk Pregnant Women and Infants (Native American Population)
4. Long Term Care (LTC)

If a Group is providing more than one TCM service, an attestation is required for each service.

An Individual (Practitioner) Level Attestation may be required for each individual enrolled to provide the following type of TCM services:

1. High Risk Pregnant Women and Infants (General Population)

2. High Risk Pregnant Women & Infants (Native American Population)

3. Long Term Care (LTC)

4. SMI

Review the bottom of the checklist for the type of TCM service the individual practitioner is providing to see if there are alternate enrollment criteria.

Some types of TCM services only require the attestation in combination with a certain license or degree. If the practitioner meets one of the criteria which does not require an attestation - and submits the proof listed - the attestation is not required.

### Whose Name and Information goes on the Attestations?

It depends on the attestation you are completing.

Group level attestations (ones which apply to the billing group) require the group's name and NPI. Group attestations say "Group" at the top of the attestation.

Individual level attestations require the individual practitioner's name and NPI. They do not say "Group" at the top of the attestation, and request the "Practitioner Name" on top.

### Who can sign the Attestations?

**Group Level Attestations:**

Must be signed by a person listed in the record as an authorized representative, managing employee, board member, or owner on the group record:

A. Please contact your organization administrator to review the record to ensure the signer is showing in one of these categories in the web portal prior to submitting the group level attestation. If the signer is not yet in the record, please have your organization administrator add them as an authorized representative and submit an updated [SFN 1168 Ownership/Controlling Interest and Conviction form](#) to add them (and any other authorized signers) to the other required sections of the record. [Instructions for the SFN 1168](#)

B. If you have not yet registered an organization administrator, please see the "Web Access Registration" article in the [Provider Enrollment FAQ](#).

C. If you have issues with your web portal accounts or passwords, please contact customer service 701-328-7098.

**Individual Level Attestations:** Must be signed by both the individual practitioner and their supervisor.

## Where do I submit the Documents?

1. Standard Email – [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com)
2. Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment

## I have questions about the Online Application.

[Click Here](#) to find out more about the online Application, including an Online Application Guide and known system issues.

## How to populate the taxonomy in the Online Application.

[Click Here](#) for a quick sheet guide on how to get the taxonomy to populate in your online application.

## Links:

[Provider Enrollment Website](#)

[Provider Enrollment FAQ](#)

[Online Application Guide](#)

[How to Populate the Taxonomy in the Online Application](#)

[List of Enrolled Providers \(by NPI\)](#)

Revision 12/16/2022

## How to Enroll an Individual

Submit a new online application. Here is a link for the online application:

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

Link to Online Application Guide:

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf>

Within **5 business days** of submitting the online application, submit the required documents. Required documents vary depending on the provider type being enrolled (Physician, Social Worker, Counselor, etc.).

**General** list of required documents:

1. Medicaid Provider Application Checklist for the correct Provider Type (LACs, LAPCs, LBSWs, Physical Therapists, RNs, Targeted Case Managers, Sole Proprietors, Non-Emergent Medical Transportation, and 1915(i) providers have separate checklists. All other practitioners fill out the general individual checklist):  
<https://www.hhs.nd.gov/human-services/medicaid/provider/medicaid-provider-enrollment-information>
2. SFN 615 – Medicaid Program Provider Agreement (Must be the current version):  
<https://www.nd.gov/eforms/Doc/sfn00615.pdf>
3. License - Submit a current legible copy of the license applicable to the provider type you are enrolling as.
4. Controlled Substance Registration Certificate (DEA) – Submit a copy of your the DEA certificate (If applicable).
5. National Provider Identifier (NPI) - Submit a copy of your NPI registration.  
<https://npiregistry.cms.hhs.gov/>

You have two options to send all documents to the Department:

1. Standard Email – [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) (please do not send EFT information, Dates of Birth (DOBs), or Social Security Numbers (SSNs) by unsecured email)
2. Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment



## How to Enroll a Group

1. Determine what taxonomy you will be billing when submitting claims for your group. There is a separate set of taxonomies for groups. You can find a list of taxonomies that North Dakota Medicaid uses for groups at this link: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf>
  - a. Once you find the taxonomy, make note of the Specialty and the Provider Type that goes with that taxonomy, you will need it to fill out the online application and checklist you will submit with your documents.
2. Use the following link to pull up the checklist for the Provider Type and Specialty you selected above: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/group-provider-checklists-pe.pdf>
  - a. Review the checklist, use the links in the checklist to access the documents you do not already have.
  - b. Make sure you have all the documents on the checklist (unless it says it does not apply. For example, the checklist tells you that if you are not tax exempt, you do not need to submit a tax exempt letter).
  - c. Access and Review the simplified instructions for filling out the SFN 1168: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-instructions-sfn1168.pdf>
  - d. Fill out all the documents and complete the checklist.
3. Fill out the online application on the “MMIS” web portal: <https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment>
  - a. Review the Online Application Guide to help with navigating, saving, and troubleshooting sections you have questions or trouble with: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf>
  - b. After the application is completed, it will bring you to a page where there is nothing for you to fill out. It will give you the one time option to print out the application. You are not required to print out the application, but if you want it for your records, this is the only time you will be able to get documentation of what you filled out.
4. Submit your documents with the checklist as a coversheet to the Department.
  - a. Include with your documents the Application Number that was assigned by the system when you completed the online application:

You have two options to send all documents to the Department:

1. Standard Email: [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) (please do not send EFT information, Dates of Birth (DOBs), or Social Security Numbers (SSNs) by unsecured email)
2. Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment

## Sole Proprietor

Enrollments for a sole proprietor are determined by the way in which the sole proprietor wishes to bill North Dakota Medicaid - through their personal SSN or through their Employer Identification Number (EIN). \*Please consult a tax professional to ensure your reporting of taxes is correct.

- If billing ND Medicaid through the sole proprietor's Social Security Number:
  - Submit an individual application.
  - The name on your 1099 will have your individual name (the legal name which matches the SSN)
- If billing ND Medicaid through the Employer Identification Number (also called EIN or FEIN) of the business:
  - Submit a group application to enroll the Tax ID as the billing provider.
  - After the group is enrolled:
    - Both the business (under the Tax ID) and the Individual (under the SSN) will need to be enrolled and affiliated to ensure claims will pay.
      - If you are already enrolled with an individual practitioner record, submit an affiliation form to "link" your individual record with your new group record.
      - If you are not yet enrolled with ND Medicaid with an individual practitioner record, submit an individual application to enroll as the "rendering" provider – Make sure to include your new group record in the Affiliations section on the Individual online application.

If a sole proprietor who enrolls under their SSN, later expands to include another provider in their business:

- Submit a group application to enroll the Tax ID of the business as the billing provider.
  - Please submit a letter along with the group application documents to advise that the business will now be the billing provider instead of the individual sole proprietor. This will allow the Department to update the sole proprietor's individual record so taxes will report under the business.
  - The new provider's services cannot be billed under the sole proprietor's SSN. In order to bill for the new provider, both the Tax ID of the business and the SSN of the new individual provider will need to be enrolled.
- After the group is enrolled
  - Submit an individual application to enroll the new provider (if they are not already enrolled).
  - If already enrolled, submit an affiliation form to "link" their individual record with the business record.

# North Dakota Department of Human Services

## What is an NPI?

“The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.” – Quoted from CMS website:

<https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProviderStand/index.html>

Please visit CMS.gov to obtain more information about NPIs, or use the link above to access their NPI page.

NPIs are obtained and maintained on the “NPPES” website: <https://nppes.cms.hhs.gov/#/>

# North Dakota Department of Human Services

## What is an Enrollment Effective Date?

An Enrollment Effective Date is the date your record will be made effective. Any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a complete application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

North Dakota Medicaid provider enrollment staff will not process a request for provider enrollment until the Program Integrity Unit (PIU) is in receipt of all required enrollment documents, in addition to submitting the online application. Unless a retroactive enrollment effective date is requested the application effective date will be the date that staff approve the application.

This policy includes adding affiliations, adding service locations and processing taxonomy changes.

Provider specialty checklists ([Individual](#)) ([Group](#)) ([NEMT](#)) ([TCM](#)) ([1915i](#)) clearly indicate the documentation required for enrollment. It is the provider's responsibility to submit complete and accurate documents that are required for enrollment purposes.

*NEMT = Non-Emergent Medical Transportation*

### Consideration for a retroactive enrollment effective date:

- A retroactive enrollment effective date is limited to no more than ninety (90) days prior to the date a complete application packet is received. Providers must request a retroactive enrollment effective date, when submitting the complete enrollment packet.
- Providers who have requested a retroactive effective enrollment date may submit claims for covered services provided prior to receipt of all required enrollment documents if the provider met all eligibility requirements at the time the service was provided and only if appropriate documentation of the services provided is maintained.

The PIU may consider a retro enrollment effective date that exceeds ninety days for situations involving emergent care provided to a ND Medicaid member. To request a retro enrollment effective date that exceeds ninety days, providers **must include a copy of the claim and medical records with their application documents.**

## Online Application – 1<sup>st</sup> Half of Enrollment Process

Please Note: North Dakota Medicaid provider enrollment staff will not process a request for provider enrollment until the PIU is in **receipt of all** required enrollment documents, in addition to submitting the online application.

A retroactive enrollment effective date is limited to no more than ninety (90) days\* prior to the date a complete application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*\*If the application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.*

For More complete coverage of the Online Application screens, please use this link to access the Online Application Guide: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf>

Link to Online Application: <https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment>

### How to Populate the Taxonomy

Make sure all the fields on the License page are closed.

1. Select the Provider Type that corresponds with your taxonomy (do not know which type to choose, see the links below)
2. Click “Add License”
  - a. Add in the license information
  - b. Click the small save to the right of the License field.
3. Click “Add Specialty”
  - a. Choose the Specialty that corresponds with your taxonomy (do not know which type to choose, see the links below)
  - b. The certification # is “00000”
  - c. Begin date is the date you are requesting your enrollment to be effective
  - d. End date is 12/31/9999
  - e. Board is “Other”
  - f. Click the small save to the right of the Specialty field
4. Click the save on the bottom of the page
5. Click “Add Taxonomy”
  - a. The taxonomy you need should be available in the drop down box
  - b. Begin date is the date you are requesting your enrollment to be effective
  - c. End date is 12/31/9999
  - d. Click the small save to the right of the Taxonomy field
6. Click the save on the bottom of the page.

**Will Not Allow the Letter “W” to be Typed**

This is a known browser compatibility issue. Workaround: Open Word, type the letter “W”, Copy, Paste wherever needed.

**End Date Required, But Information is Still Current**

Use 12/31/9999

**Specialty Requires Certification Number, But There is No Board Certification for this Specialty**

Use “00000”

# North Dakota Department of Human Services

## How To: Select a Taxonomy in the Online Application

Make sure all the fields on the License page are closed.

1. Select the Provider Type that corresponds with your taxonomy (do not know which type to choose, see the links below)
2. Click “Add License”
  - a. Add in the license information
  - b. Click the small save to the right of the License field.
3. Click “Add Specialty”
  - a. Choose the Specialty that corresponds with your taxonomy (do not know which type to choose, see the links below)
  - b. The certification # is “00000”
  - c. Begin date is the date you are requesting your enrollment to be effective
  - d. End date is 12/31/9999
  - e. Board is “Other”
  - f. Click the small save to the right of the Specialty field
4. Click the save on the bottom of the page
5. Click “Add Taxonomy”
  - a. The taxonomy you need should be available in the drop down box
  - b. Begin date is the date you are requesting your enrollment to be effective
  - c. End date is 12/31/9999
  - d. Click the small save to the right of the Taxonomy field
6. Click the save on the bottom of the page.

Link to Provider Type/Specialty/Taxonomy List for Individual Applications:

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

Link to Provider Type/Specialty/Taxonomy List for Group Applications:

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf>

# North Dakota Department of Human Services

## What is the CP 575/147C?

The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter providers receive from the IRS granting their Employer Identification Number (EIN). A copy of your CP 575 is required to verify the provider or supplier's legal business name and EIN. If you are not able to locate the first EIN letter, you can get a 147C letter from the IRS. This is a different type of EIN verification. See the IRS website for more information on how to obtain the letter:

<https://www.irs.gov/businesses/small-businesses-self-employed/lost-or-misplaced-your-ein>





# Governmental Information Letter

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Government entities are frequently asked to provide a tax-exempt number or “determination” letter to prove its status as a “tax-exempt” or charitable entity. For example, applications for grants from a private foundation or a charitable organization generally require this information as part of the application process. In addition, donors frequently ask for this information as substantiation that the donor’s contribution is tax deductible, and vendors ask for this to substantiate that the organization is exempt from sales or excise taxes. (Exemption from sales taxes is made under state law rather than Federal law.)

The Internal Revenue Service does not provide a tax-exempt number. A government entity may use its Federal TIN (taxpayer identification number), also referred to as an EIN (Employer Identification Number), for identification purposes.

Governmental units, such as states and their political subdivisions, are not generally subject to federal income tax. Political subdivisions of a state are entities with one or more of the sovereign powers of the state such as the power to tax. Typically they include counties or municipalities and their agencies or departments. Charitable contributions to governmental units are tax-deductible under section 170(c)(1) of the Internal Revenue Code if made for a public purpose.

An entity that is not a political subdivision but that performs an essential government function may not be subject to federal income tax, pursuant to Code section 115(1). The income of such entities is excluded from the definition of gross income as long as the income (1) is derived from a public utility or the exercise of an essential government function, and (2) accrues to a State, a political subdivision of a state, or the District of Columbia. Contributions made to entities whose income is excluded income under section 115 may be tax deductible to contributors.

In order for a government entity to receive a determination of its status as a political subdivision, instrumentality of government, or whether its revenue is exempt under Internal Revenue Code section 115, it must obtain a letter ruling by following the procedures specified in [Revenue Procedure 2018-1](#) or its successor. There is a fee associated with obtaining a letter ruling.

## Video

- [Governmental Information Letter Video](#)

As a special service to government entities, IRS will issue a “governmental information letter” free of charge. This letter describes government entity exemption from Federal income tax and cites applicable Internal Revenue Code sections pertaining to deductible contributions and income exclusion. Most organizations and individuals will accept the governmental information letter as the substantiation they need.

Government entities can request a governmental information letter by calling 1-877-829-5500.

*Page Last Reviewed or Updated: 15-Aug-2018*