North Dakota 1915(i) Medicaid Academy Orientation and Provider Enrollment

October 25, 2022

ND Medicaid Academy

This presentation is not a substitute for official guidance from the North Dakota Department of Human Services.

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WELCOME TO THE NORTH DAKOTA MEDICAID ACADEMY

Opening Remarks

NORTH Dakota | Human Services
Be Legendary.™

Help is here

NORTH Dakota | Behavioral Health HUMAN SERVICES
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Your training TEAM

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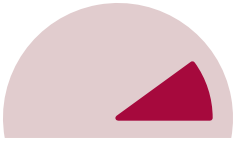
Where are you located?

Click the **Pencil Icon** (top-left), then the **Arrow** and **click on the map** to drop an arrow on your location.

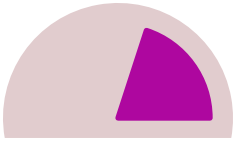
Then, turn off your Arrow by clicking on the **Arrow** again.

Before We Begin… Where are you in the ND Medicaid 1915(i) provider enrollment process for your agency?

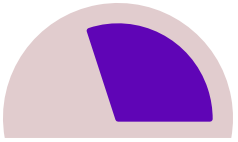
Haven't yet started the agency application



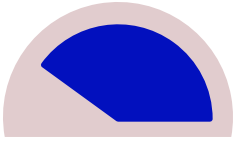
Started but haven't submitted the agency application



Submitted the agency application



Asked to make revisions to the application



Approved to provide services

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Medicaid Academy Schedule

Topic	Date	Tools
Orientation and Provider Enrollment	**10/25/22**	**Provider Enrollment Guide**
Provider Enrollment Q&A	10/27/22	
Services Participant Enrollment	11/1/22	Participant Eligibility Tracker
Services Participant Enrollment Q&A	11/3/22	
Staffing and Budgeting	11/8/22	Services Budget Tool, Time Study Materials
Staffing and Budgeting Q&A	11/10/22	
Policies and Procedures	11/15/22	Sample Policies and Procedures
Policies and Procedures Q&A	11/17/22	
Documentation and Billing	11/29/22	Billing Guide
Documentation and Billing Q&A	12/1/22	
Quality Assurance	12/6/22	
Quality Assurance Q&A	12/8/22	

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Purpose of Medicaid Academy Learning Sessions

DHS provides the "WHAT"/ Policy Requirements

The TA Team helps with "HOW" so you can develop a plan for your agency

Each session will include:

Helpful tips and tools provided by the TA team	Opportunities for sharing experiences across agencies	Coaching for your agency

Your Team includes:

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Throughout the Academy

Training focused on a particular topic

Tools

Time for Team Work planning

Time for Questions

- Some can be answered right away! Can you bill for Travel- NO!
- Some will need some research and will be part of a developing FAQ throughout the process.

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Once Academy Ends

Your team will leave the academy with a work plan to be implemented in the coming months.

After the Academy ends, members of the TA team will be meeting with agencies individually to support your implementation of your work plan

Plan for Today:

Session 1

Orientation

Provider Enrollment Process

Introductions & Expectations

- Name
- Agency
- Your role at the agency

- What you hope to gain from the Medicaid Academy and/or your expectations for these next six weeks.
- Every week, we will have a learning session on Wednesday and a Q&A session on Friday of the same week*.

Organizational Capacity

What can you expect to be impacted as your agency becomes a Medicaid Provider?

What is impacted at the agency-level when becoming a Medicaid provider?

- Programmatic
  - Service provision
  - Staffing & Training
- Strategic
  - Business partnerships
  - Strategic long-term planning
- Analytical
  - Data management
  - Quality Assurance
- Logistic
  - Financial operations
  - Legal agreements
  - HR considerations

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Shared Tools and Materials

Medicaid Academy Materials

- 1915(i) Trainings | Health and Human Services North Dakota
- Web site will include:
  - Recordings of these trainings
  - Slide Decks

Tools

- Tool for today- the Group Provider Enrollment Guide

Getting the most out of the Academy

Get clear on team member roles and your team end goal

Access the shared tools, download and try them out

Take advantage of technical assistance offered

Ask questions to understand where to focus YOUR time.

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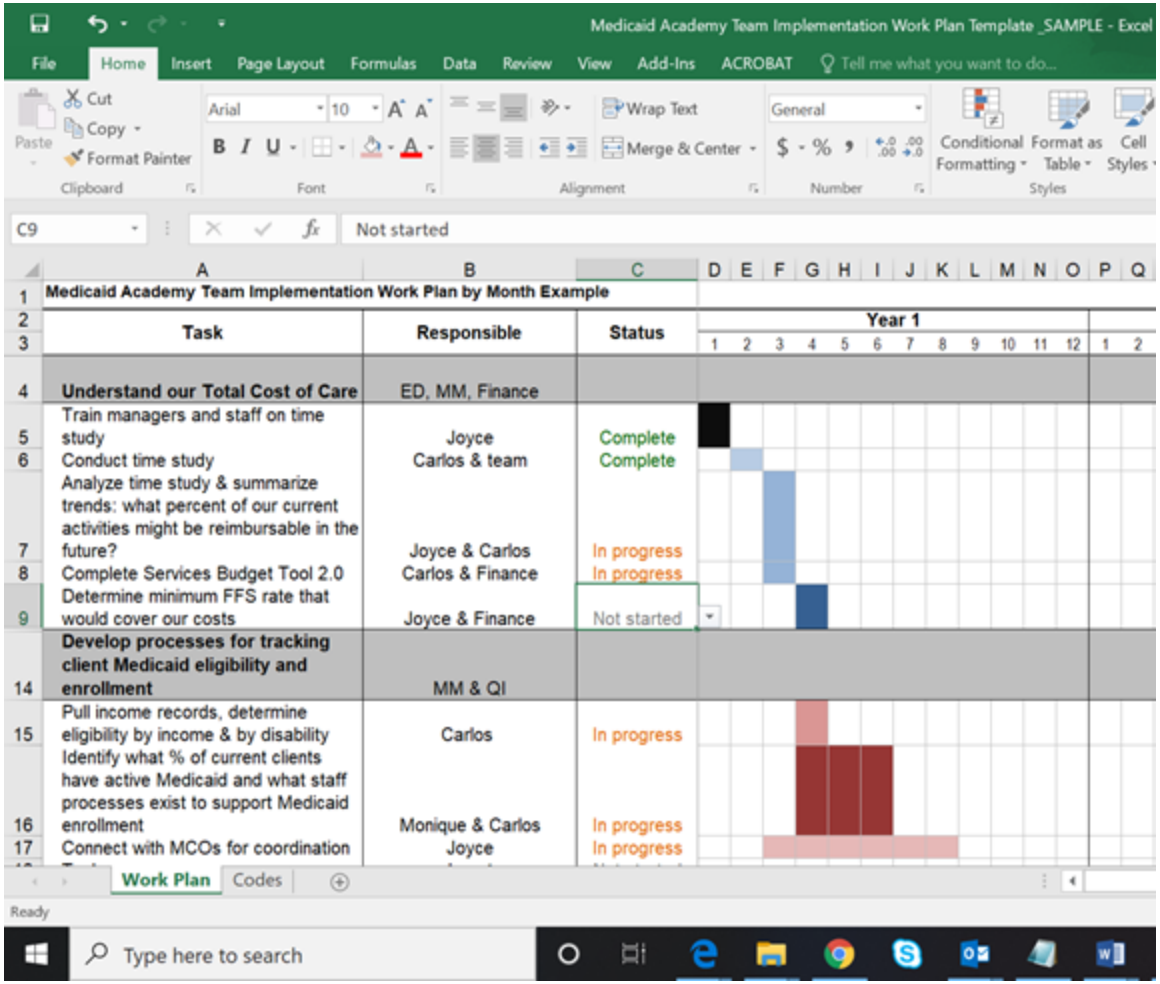
What did you learn from your….

Provider Readiness Assessment Checklist

Agency TA Needs Assessment

Tell us what you found from completing the Provider Readiness Tools

Team Workplan Template Example



[Work plan template]

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Between meetings, determine-

1. When will our team meet?
2. What platform are you using to continue with the work plan throughout the Academy and beyond?
    1) Good if coaches as well as agency team members can access.
3. What did you learn from the provider readiness process that tells you what to work on right away?

Break: 10 minutes

Provider Enrollment

State Process for all providers that bill Medicaid

The Role of Provider Enrollment

Data System Role

- Verify Eligibility and Enrollment for all individuals
- Verify Agency's Status with ND DHS

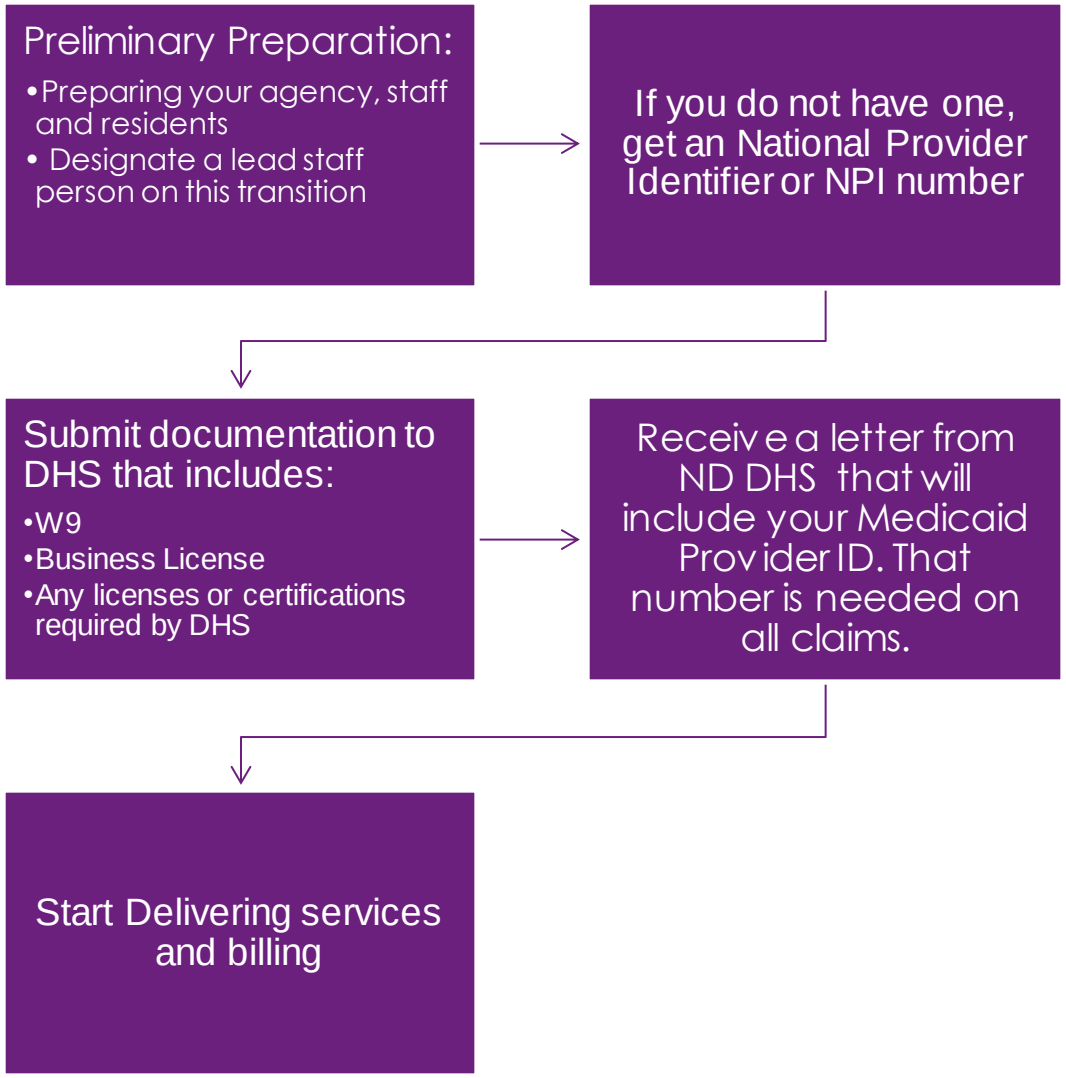
Provider Requirements

- Central location for information on providers
- Determining what is needed to ensure an adequate network

Prevent Fraud and abuse

- Enroll only providers with o history of fraud or abuse
- Process to ensure the state compliance with federal requirements

Becoming a Medicaid Biller in North Dakota



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Two Types of Provider Enrollment

Group Enrollment

enrolling your agency– ***today's presentation***

Individual Enrollment

enrolling each provider (Direct Services Staff) at your agency

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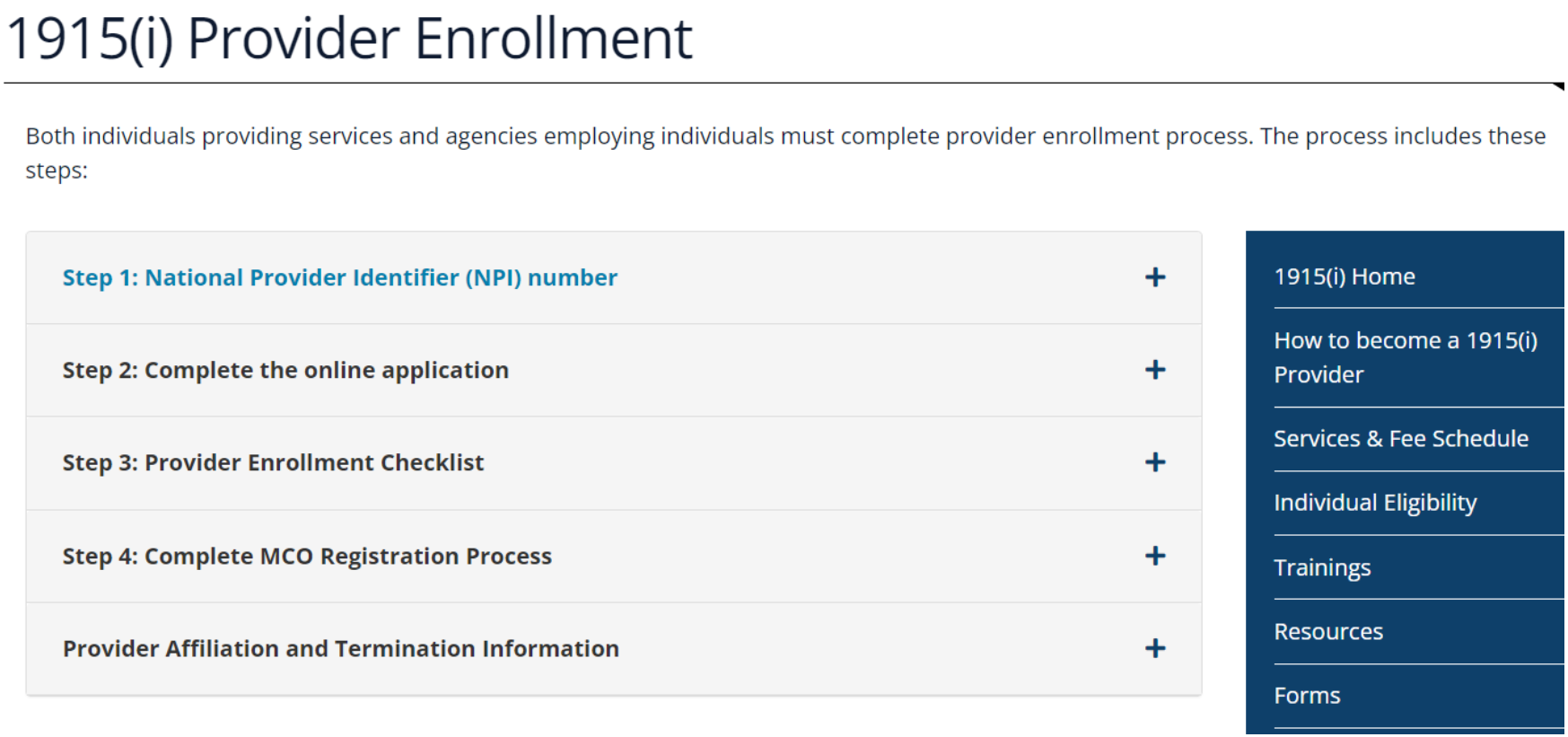
Steps for 1915(I) Provider Enrollment



1915(i) Provider Enrollment

Both individuals providing services and agencies employing individuals must complete provider enrollment process. The process includes these steps:

- **Step 1: National Provider Identifier (NPI) number** +
- **Step 2: Complete the online application** +
- **Step 3: Provider Enrollment Checklist** +
- **Step 4: Complete MCO Registration Process** +
- **Provider Affiliation and Termination Information** +

1915(i) Home
How to become a 1915(i) Provider
Services & Fee Schedule
Individual Eligibility
Trainings
Resources
Forms

https://www.hhs.nd.gov/1915i/process-overview

ND MMIS Web Portal for 1915(i) Group Provider Enrollment

ND MMIS Web Portal

- Your agency will need to complete the provider enrollment process in the ND MMIS Web Portal as well.
- This is where you will receive your application tracking number, which needs to be listed on the Coversheet and Group Application Checklist (page 1) PDF files.
- MMIS Web Portal Provider Enrollment Homepage: https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment
- DHS 1915(i)Web Portal Provider Enrollment Guide: https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/provider-enrollment-application-guide.pdf

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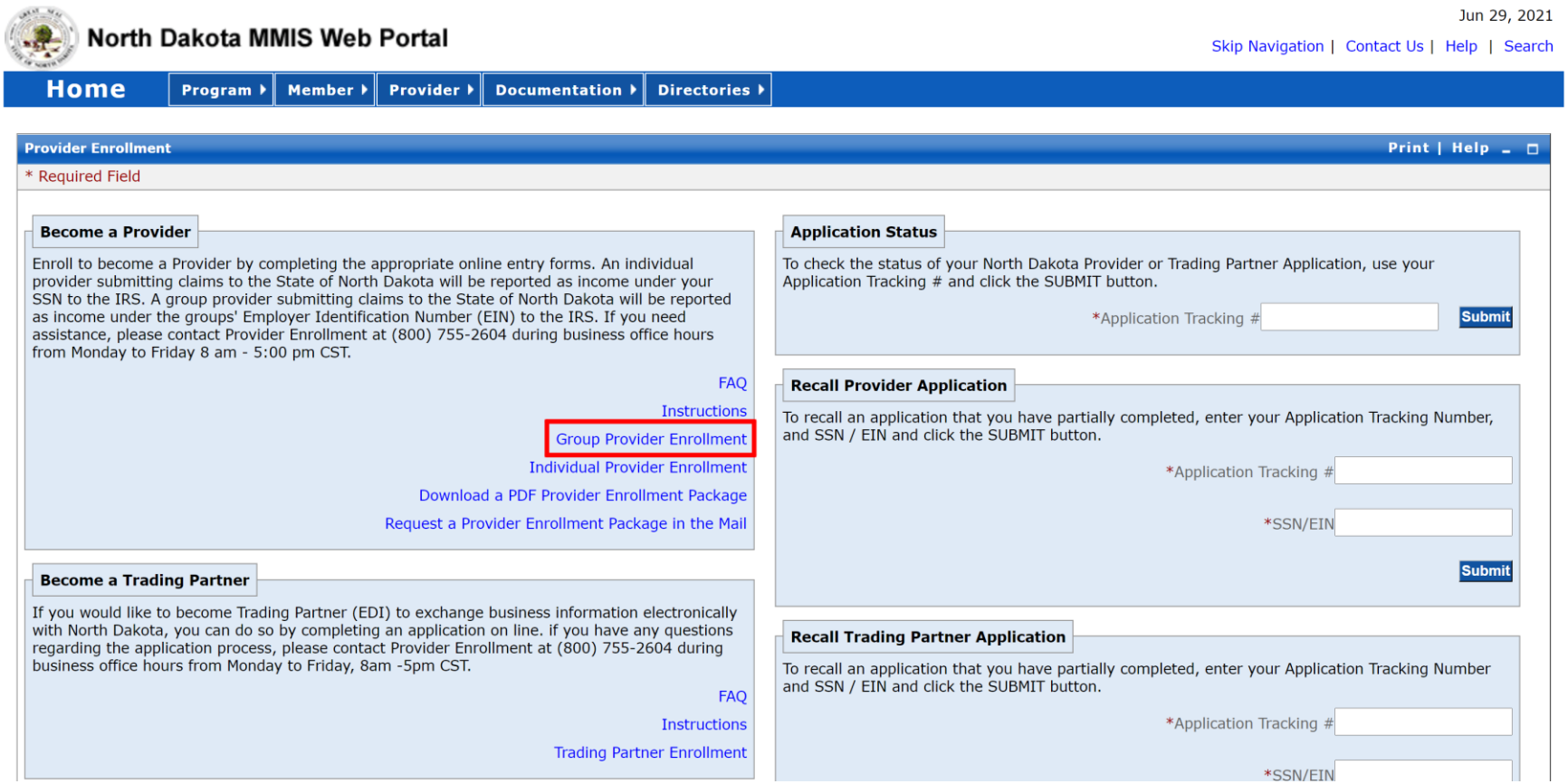
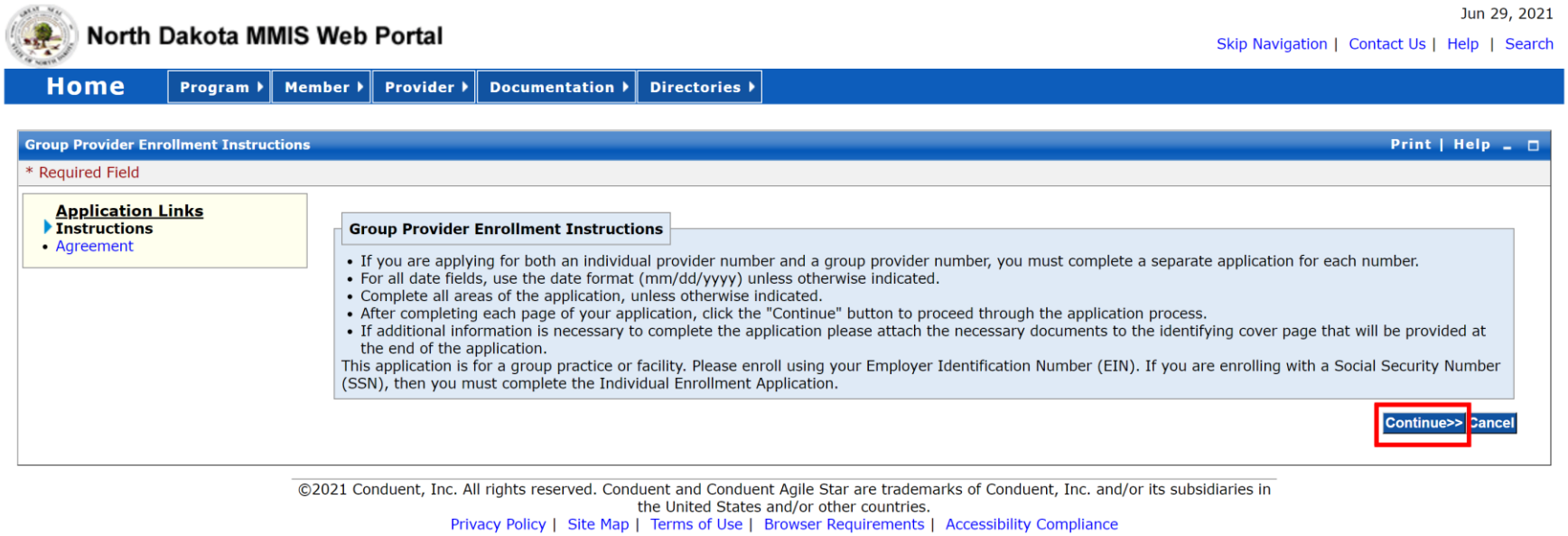
In the Provider Enrollment process your agency is agreeing to:

- Follow all state and federal rules around Medicaid funding including
  - Have a National Provider Identifier (NPI) number and keep it current and active
  - Not discriminate against protected classes
  - HIPAA
  - Allow DHS access to records and audits as requested. Keep records for up to 7 years

Provider Enrollment Homepage

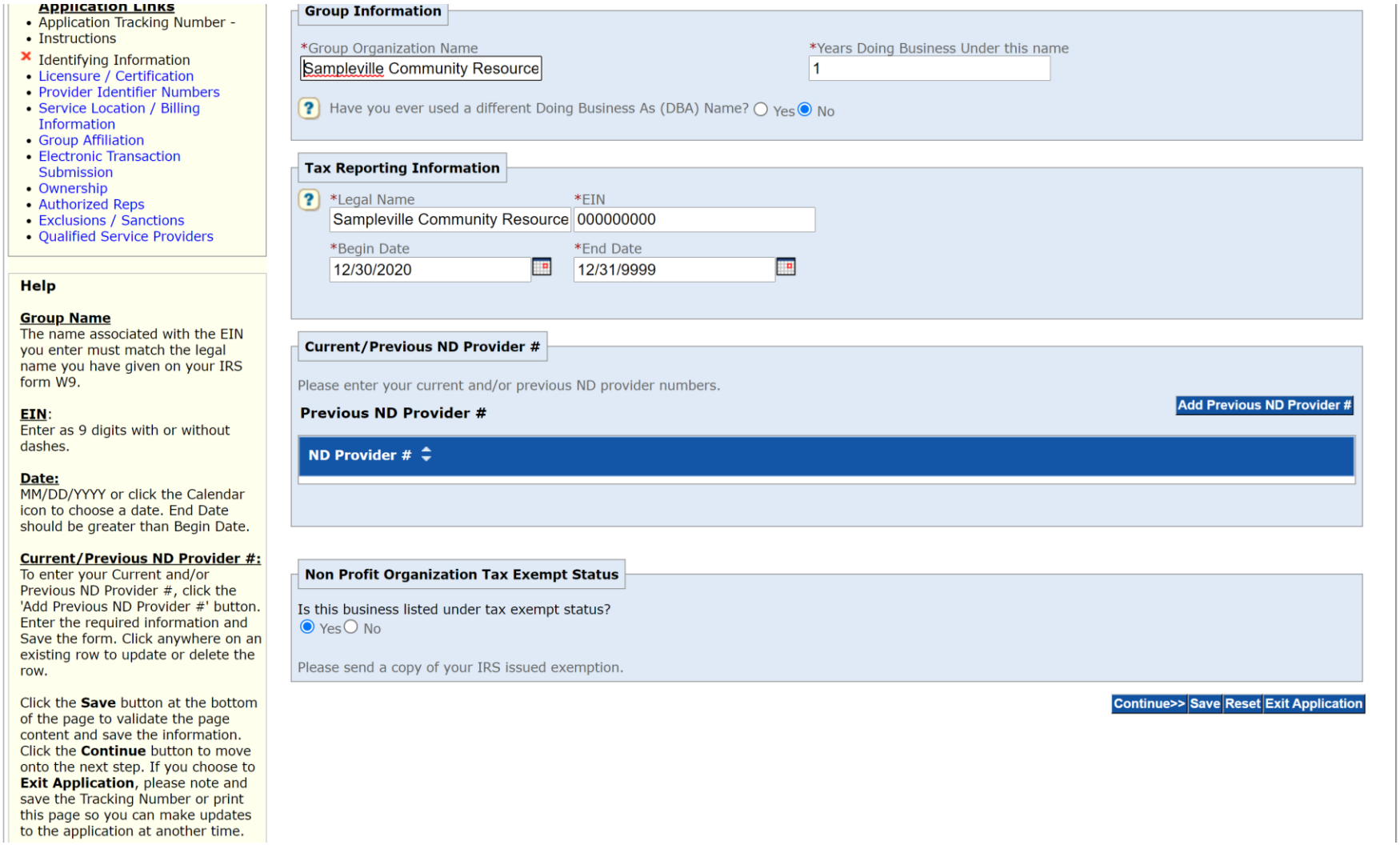


Provider Enrollment Instructions



Provider Enrollment Acknowledgement

Screen 1: Identifying Information



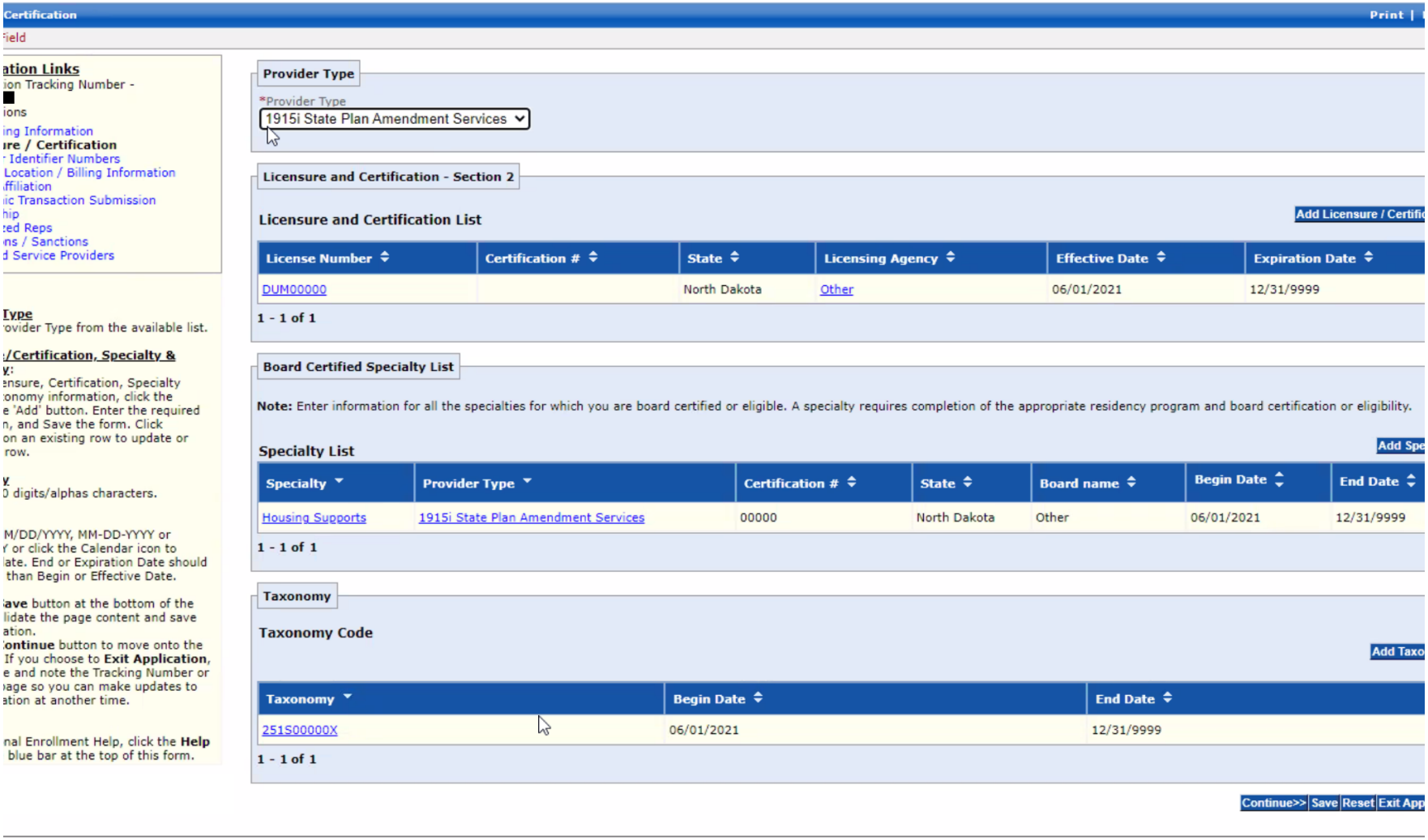
Screen 1: Identifying Information – Application Guide Notes

Screen 1 - Identifying Information

Notes:

- Group Organization Name = DBA (Doing Business As).
- Legal Name = Name as Reported to the IRS.
- EIN = Tax ID #/FEIN.
- Begin Date is the EIN was first issued, End Date is 12/31/9999.
- Tax Exempt – If Yes is selected, you will need to submit your Tax Exempt Letter from the IRS (federal, not state) along with your application documents.

Screen 2: Licensure / Certification



Screen 2: Licensure / Certification – Application Guide Notes

Screen 2 – Licensure/Certification

- A list of Provider Types along with their corresponding Specialties, and Taxonomies can be found on our website. Link: http://www.nd.gov/dhs/info/mmis/docs/mmis-group-provider-code-taxonomy.pdf
- License. Enter the license or certification that is required for the type of services you are enrolling to provide.

  If no license or certification is required, enter the following as a license:
  - License Number: "DUM00000"
  - State: State you are providing services in
  - Licensing Agency: "Other"
  - Effective Date: The date you are requesting your enrollment to be effective
  - Expiration Date: 12/31/9999
- Specialty. Certification # is "00000", State is the same as the license, Board Name is Other, begin date is the Claim Submission Effective Date (Date the enrollment with Medicaid will be effective), End date is 12/31/9999.
- Taxonomy
  - Populates after the Provider Type, License, and Specialty are input. Make sure the license field and Specialty field are saved and closed. Click the little save on each field to close them. Then click add Taxonomy. The box should have a prepopulated taxonomy. This is the only taxonomy available for the Provider Type and Specialty you have selected. The Taxonomy cannot be typed, you must use the drop down box.
  - Taxonomy should match the provider's NPI, if not, please determine if you need to select a different Type and Specialty or update the provider's NPI.

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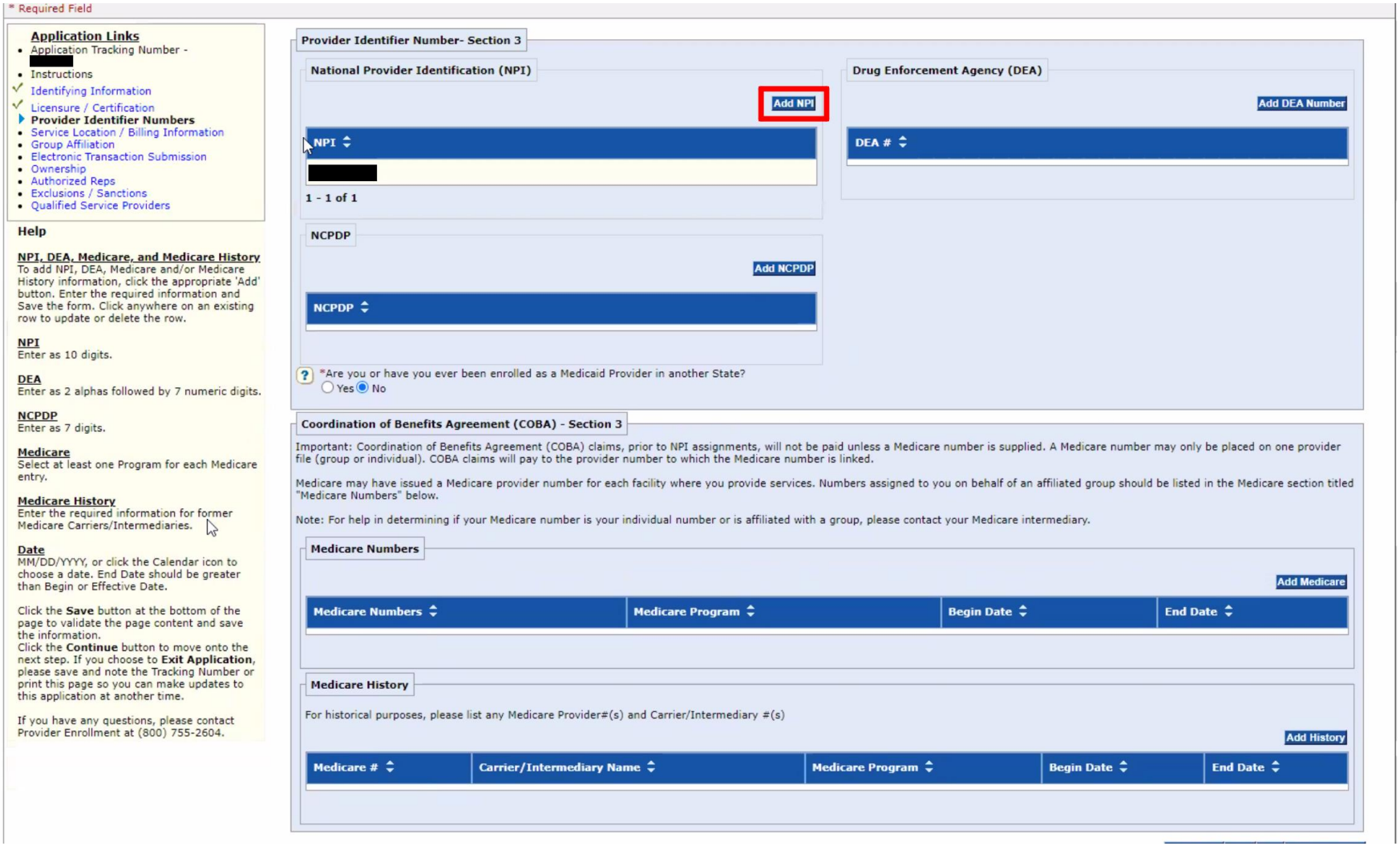
Screen 3: Provider Identifier Numbers



Screen 3: Provider Identifier Numbers – Application Guide Notes

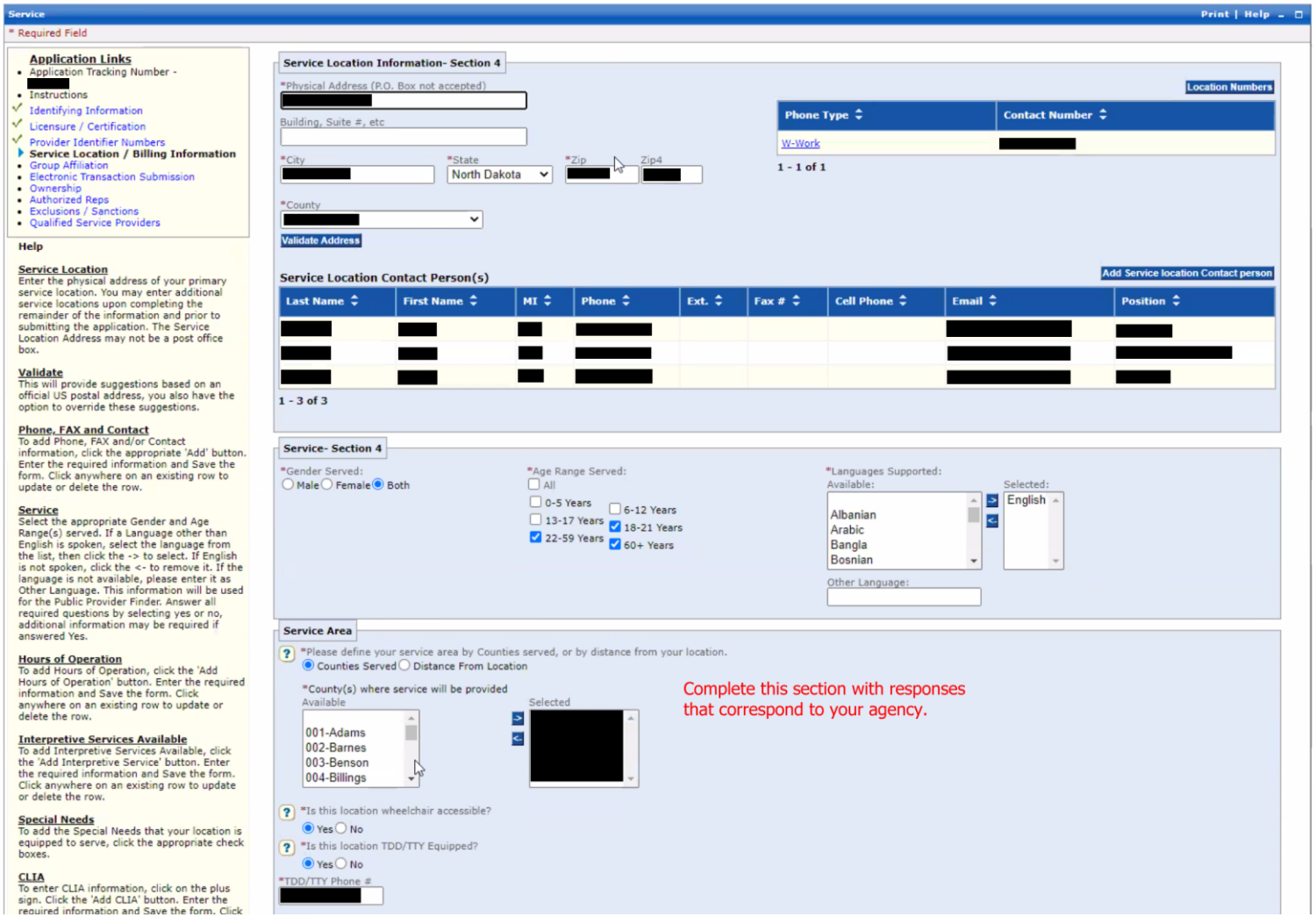
Screen 3 – Provider Identifier Numbers

- Group/Organizational NPI is required for all provider types except Transportation, Lodging, Meals, and DD (Developmental Disabilities providers).
- DEA is not required.

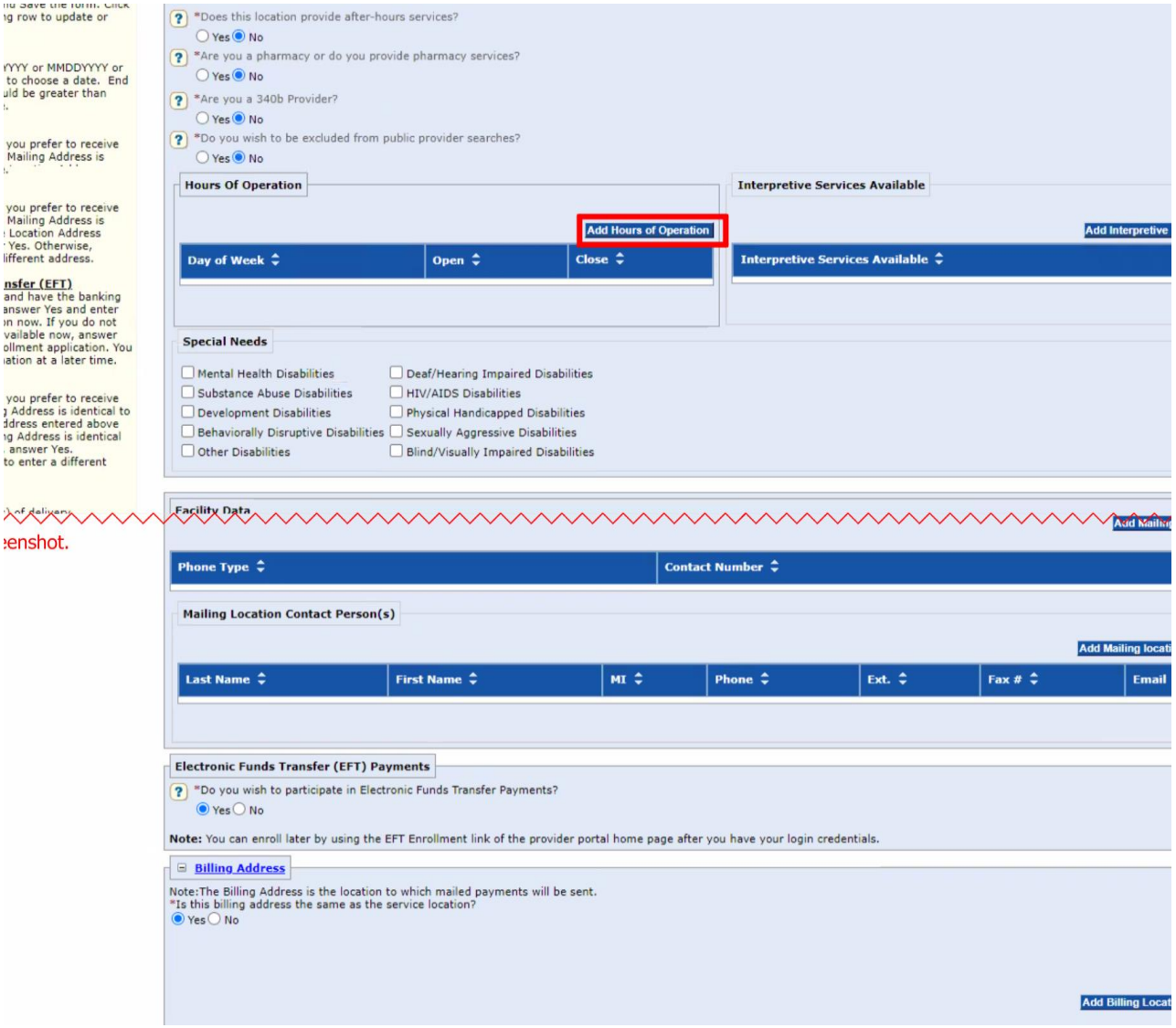
Created 8/24/2017
Revised 4/28/2021

- If still enrolled with Medicare, end date is 12/31/9999.

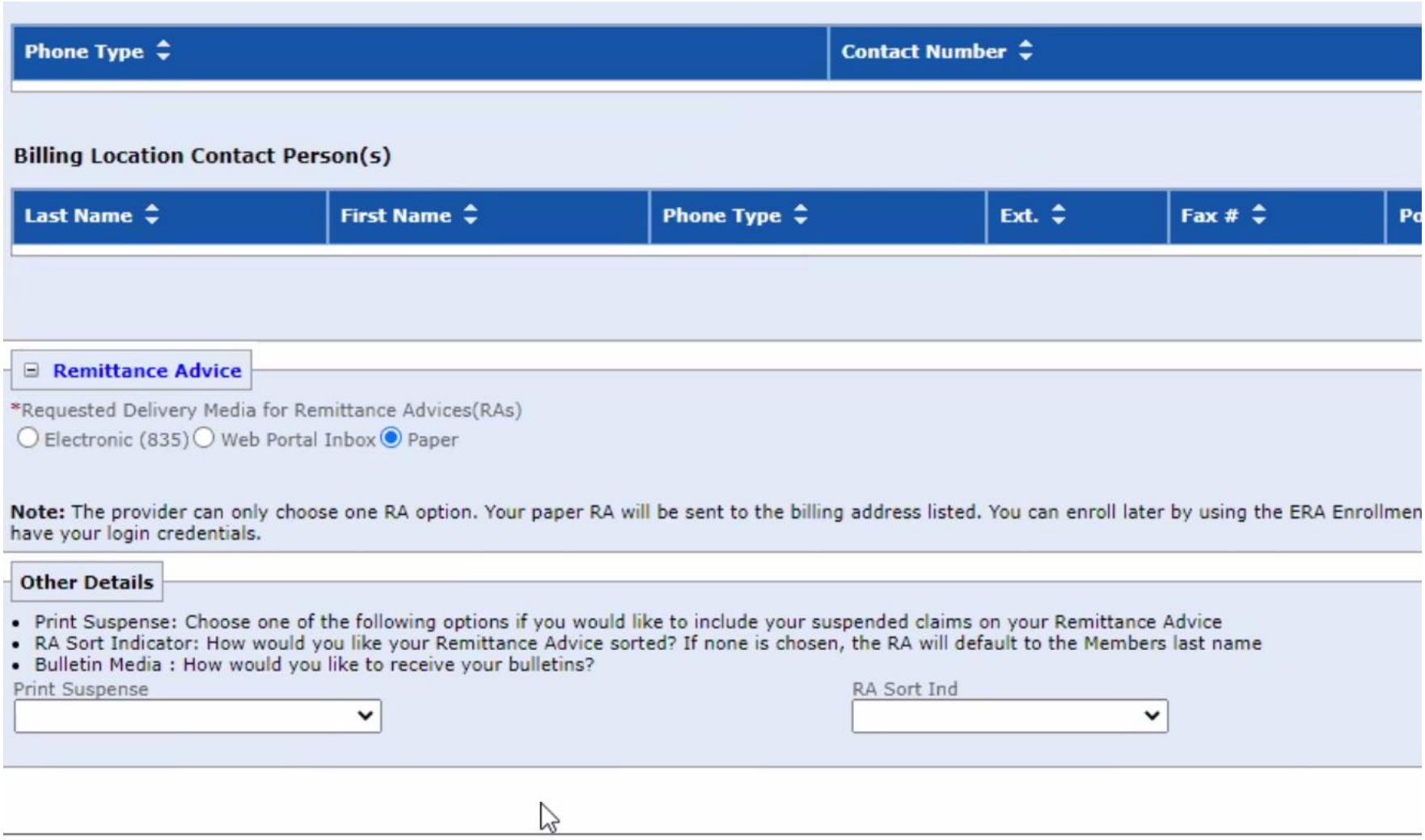
Screen 4: Service Location / Billing Information (1/3)



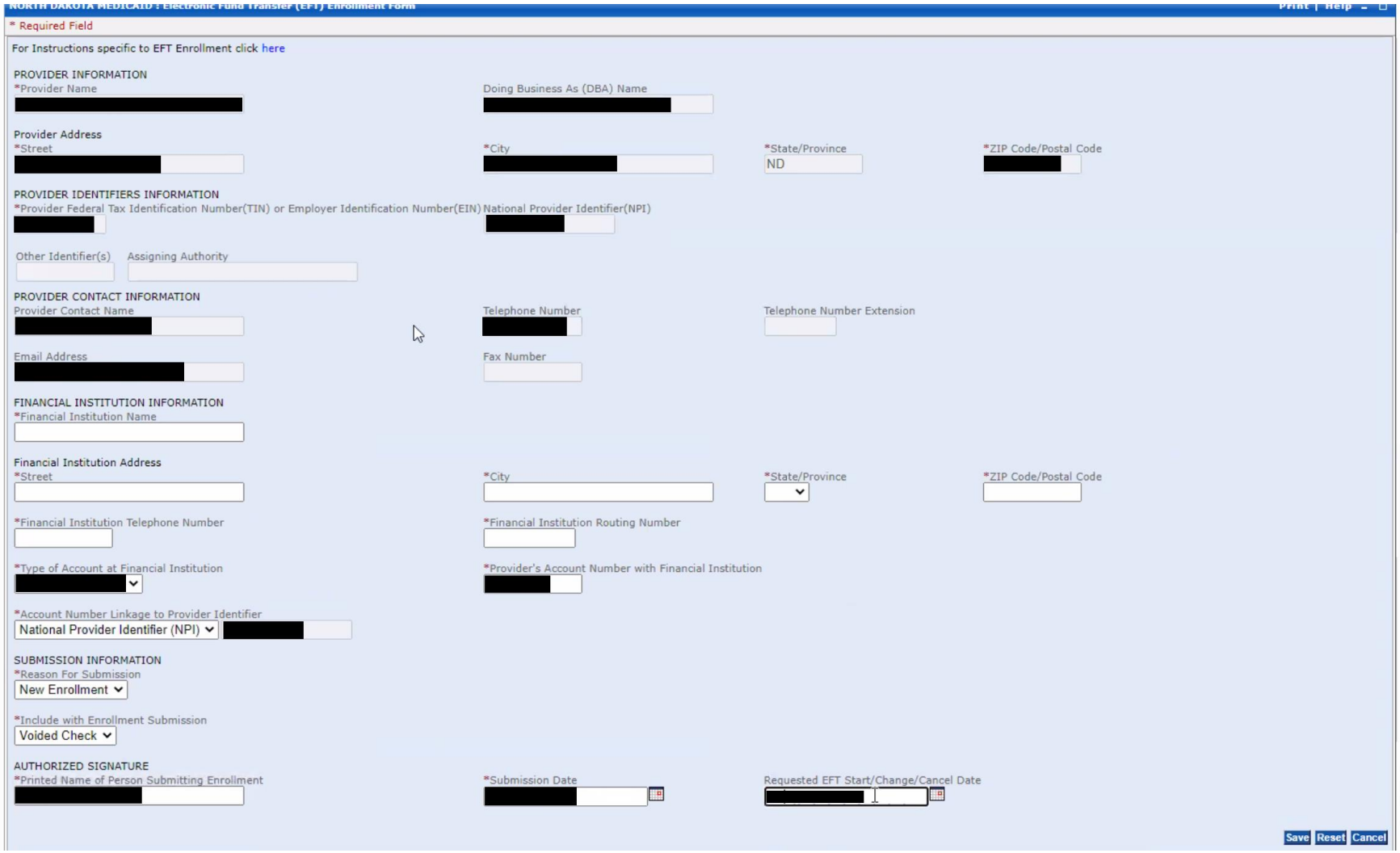
Screen 4: Service Location / Billing Information (2/3)



Screen 4: Service Location / Billing Information (3/3)



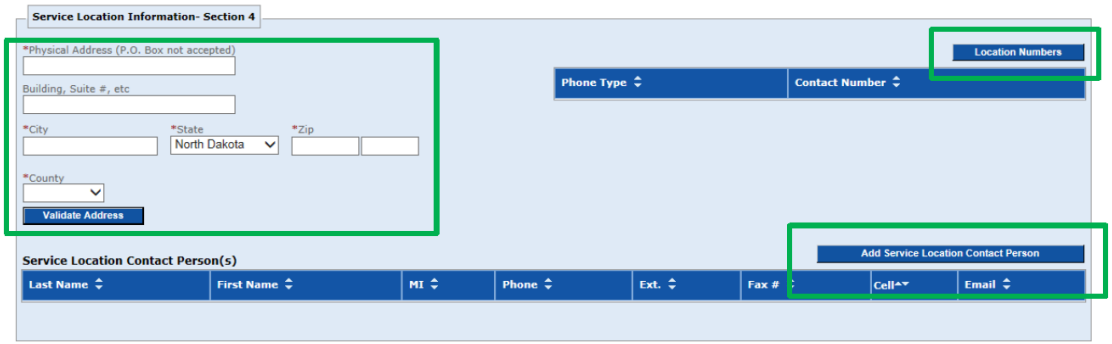
Screen 4a: EFT Enrollment Form



Screen 4: Service Location / Billing Information – Application Guide Notes

Screen 4 – Service Location Billing

- Service Location Information
  - Primary service location address.
    - Enter Address, Click "Validate Address"
    - Choose either the address the system suggests or choose "override verification warning" to use the exact address you entered. Click "Submit".
  - **Required**: "Location Numbers" – Enter the phone number for the primary service location.
  - **Required**: Enter Service Location Contact Person – Include First and Last Name, Phone, and Email.



- Service Area
  - TDD/TTY is used by deaf and mute individuals to communicate by phone.
  - Public Provider searches display
  - 340b Providers are usually limited to pharmacies.
- CLIA – Enter if applicable.
- **Required**: Mailing and Billing Addresses/Numbers.
  Include the Mailing and Billing Location Numbers.
  Mailing and Billing Contact Persons are not required. Enter if applicable.
- EFT
  - If Yes: Enter EFT. Will need to submit the SFN 661 (EFT form) and a bank letter with your application documents.
  - If No: Will receive paper check (please ensure your billing address is correctly entered).
- "Other Details" section is not required

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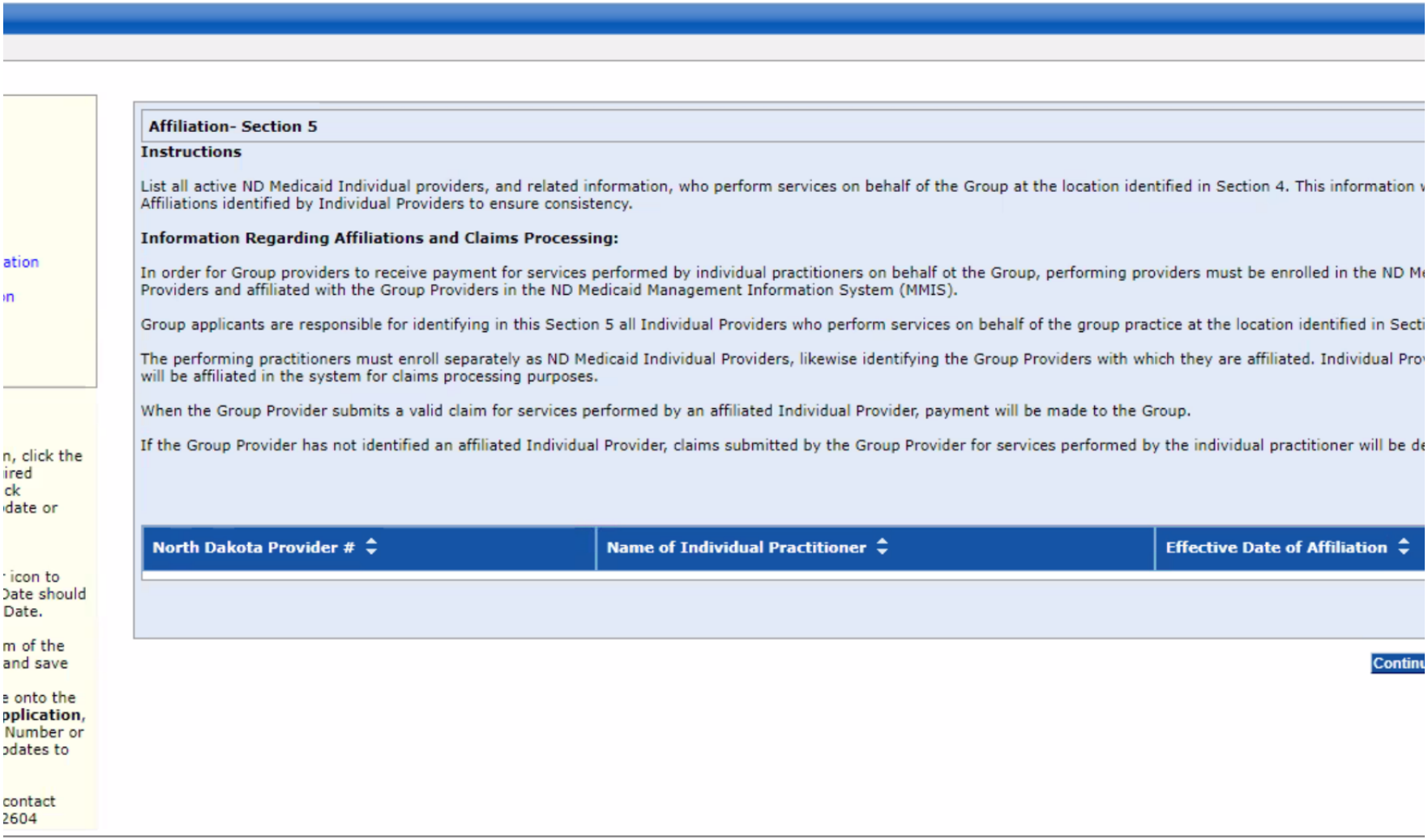
Screen 5: Group Affiliation



Affiliation- Section 5

Instructions

List all active ND Medicaid Individual providers, and related information, who perform services on behalf of the Group at the location identified in Section 4. This information v
Affiliations identified by Individual Providers to ensure consistency.

Information Regarding Affiliations and Claims Processing:

In order for Group providers to receive payment for services performed by individual practitioners on behalf ot the Group, performing providers must be enrolled in the ND M
Providers and affiliated with the Group Providers in the ND Medicaid Management Information System (MMIS).

Group applicants are responsible for identifying in this Section 5 all Individual Providers who perform services on behalf of the group practice at the location identified in Secti

The performing practitioners must enroll separately as ND Medicaid Individual Providers, likewise identifying the Group Providers with which they are affiliated. Individual Pro
will be affiliated in the system for claims processing purposes.

When the Group Provider submits a valid claim for services performed by an affiliated Individual Provider, payment will be made to the Group.

If the Group Provider has not identified an affiliated Individual Provider, claims submitted by the Group Provider for services performed by the individual practitioner will be de

North Dakota Provider #	Name of Individual Practitioner	Effective Date of Affiliation

Continu

Screen 5: Group Affiliation – Application Guide Notes

Screen 5 –Affiliation

- Individuals entered in this section must be enrolled prior to the submission of this application.

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Revised 4/28/2021

- Enter the ND Medicaid Provider ID # (7 digits). If you do not know their Provider #, you may enter their NPI.
- The Effective Date of the affiliation is the individual's earliest date of service for your facility.
  - Cannot be before the individual's effective date of enrollment with ND Medicaid.
  - Cannot be before the Claim Submission Effective Date being requested on the group application.
  - Cannot be more than 1 year from the date the group application is approved.

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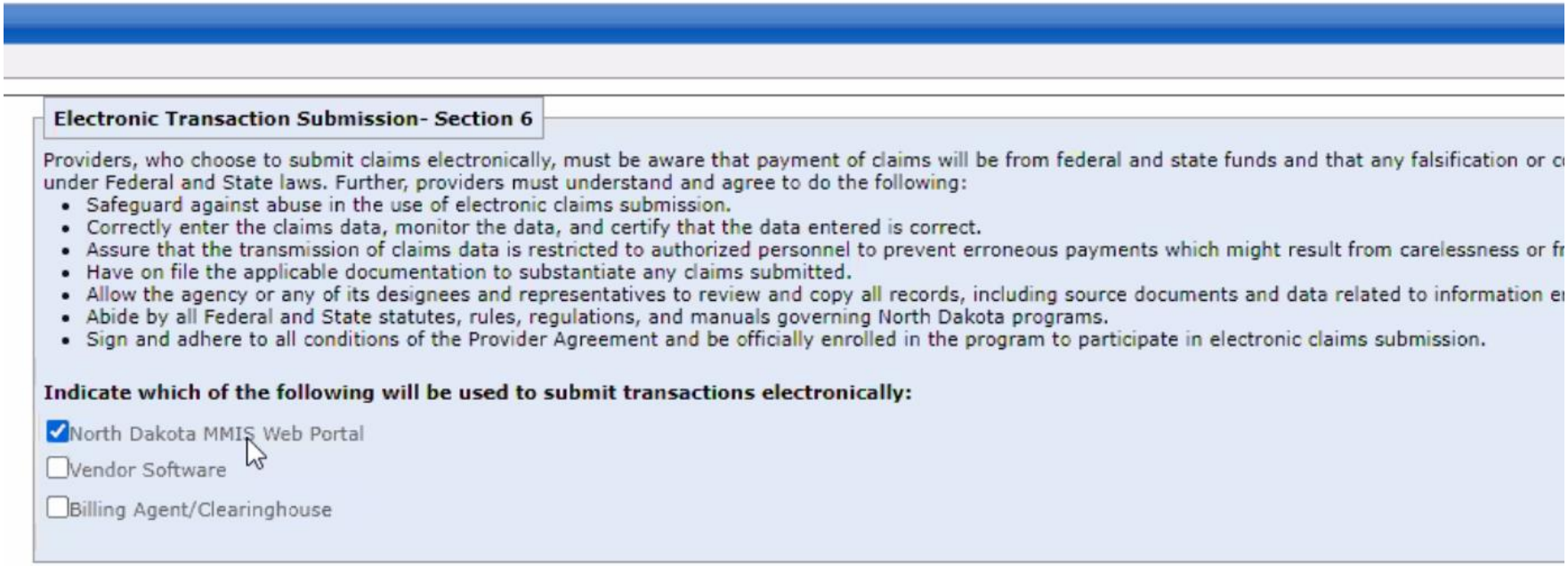
Screen 6: Electronic Transaction Submission

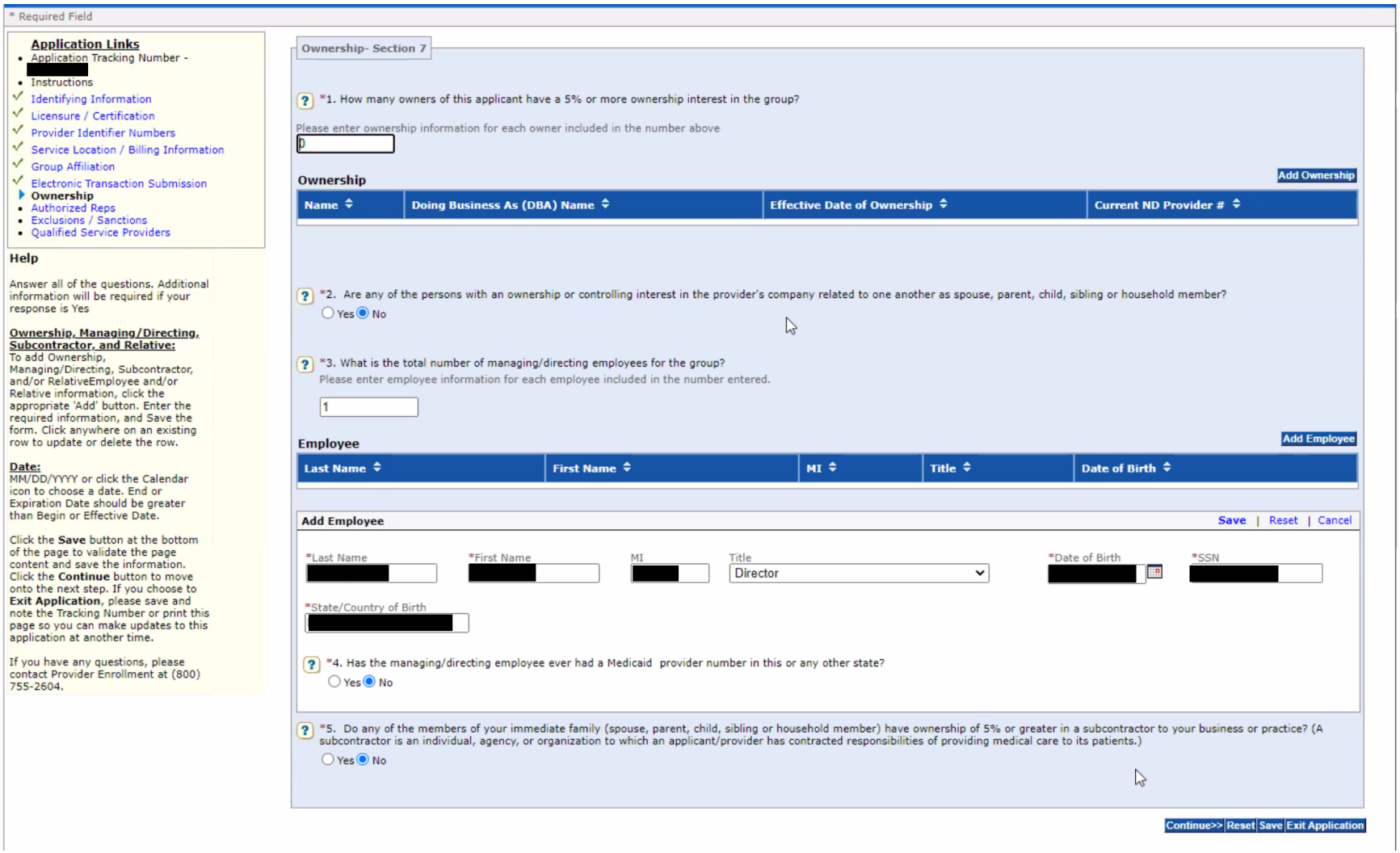


Screen 6: Electronic Transaction Submission – Application Guide Notes

Screen 6 – Electronic Transaction Submission

- If you use vendor software or have a 3rd party billing agent or clearinghouse, please consult them with any questions regarding this section.
- If you will be submitting your claims directly to the Department through our online Web Portal, please select “North Dakota MMIS Web Portal”.

Screen 7: Ownership

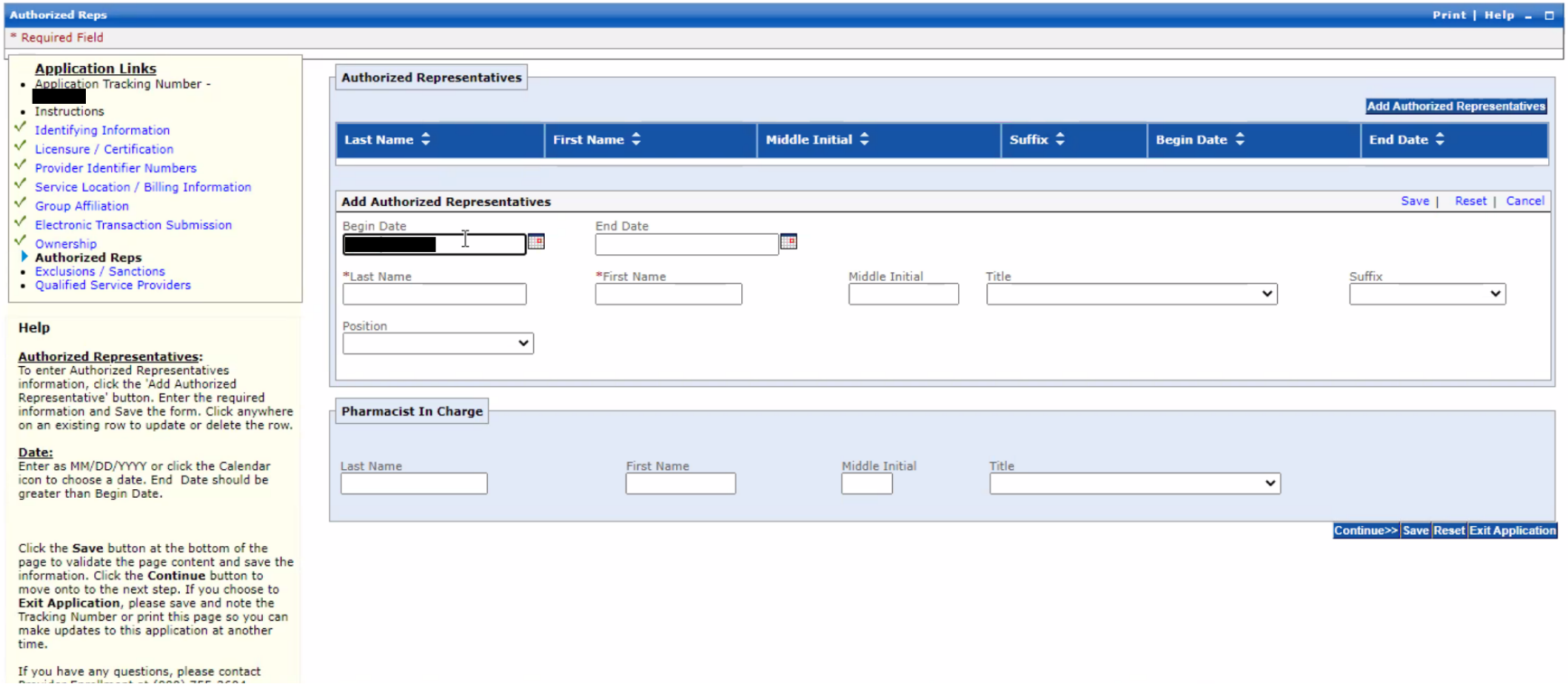


Screen 7: Ownership – Application Guide Notes

Screen 7 – Ownership

- Answer questions 1-5.
- Add Owners in Question 1, if applicable.
- Add Managing/Directing Employees, if applicable.

Screen 8: Authorized Representatives

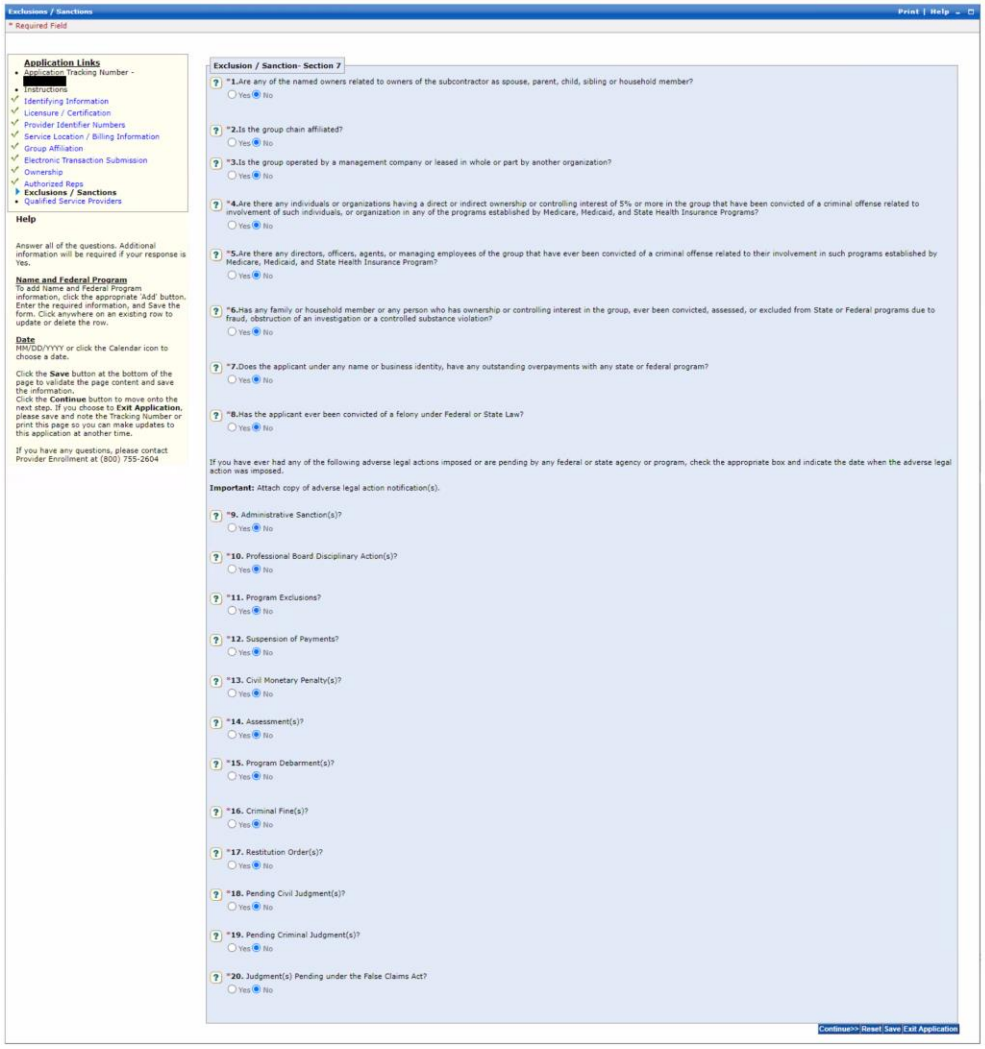


Screen 8: Authorized Representatives – Application Guide Notes

Screen 8 – Authorized Reps

- Add all Authorized Representatives. Please include a begin date. End date is 12/31/9999.
- Pharmacist In Charge: Only for Pharmacy Applications.

Screen 9: Exclusions / Sanctions

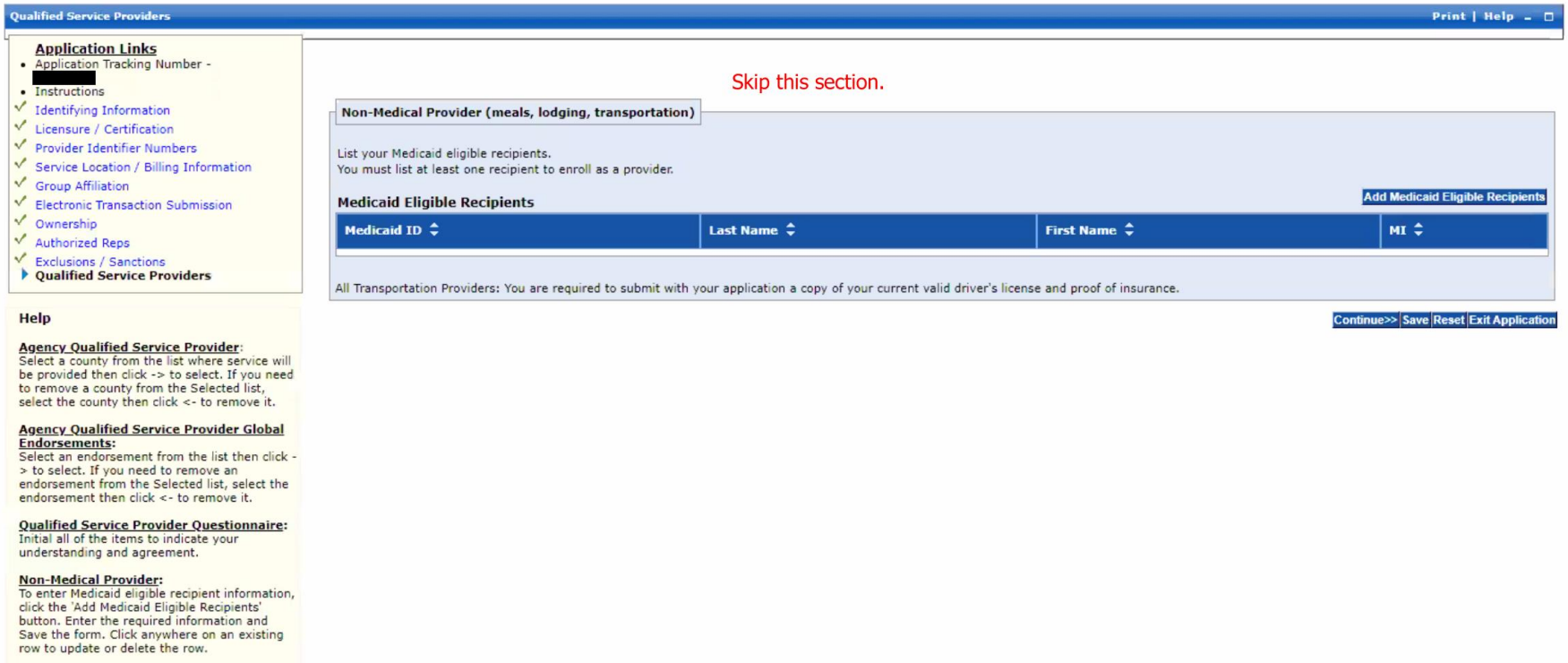


Screen 9: Exclusions / Sanctions – Application Guide Notes

Screen 9 – Exclusion/Sanction

- Answer Yes or No to each question.
- If Yes, submit the adverse legal action documentation to the Department with your application documents.

Screen 10: Qualified Service Providers

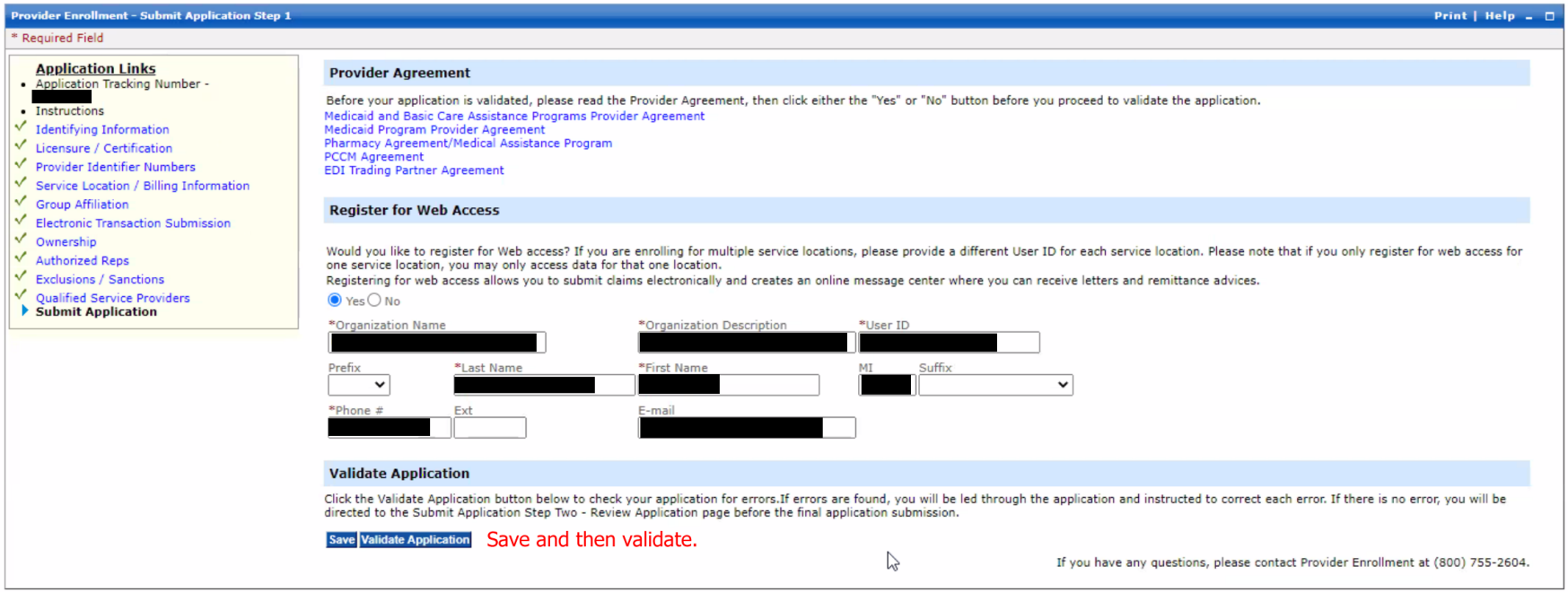


Screen 10: Qualified Service Providers – Application Guide Notes

Screen 9 – Qualified Service Providers/Non-Medical Provider

- Section not required.
- If you are a Transportation, Lodging, or Meals Provider, this section is still not required.

Screen 11: Submit Application Step 1



Screen 11: Submit Application
Step 1 – Application Guide Notes

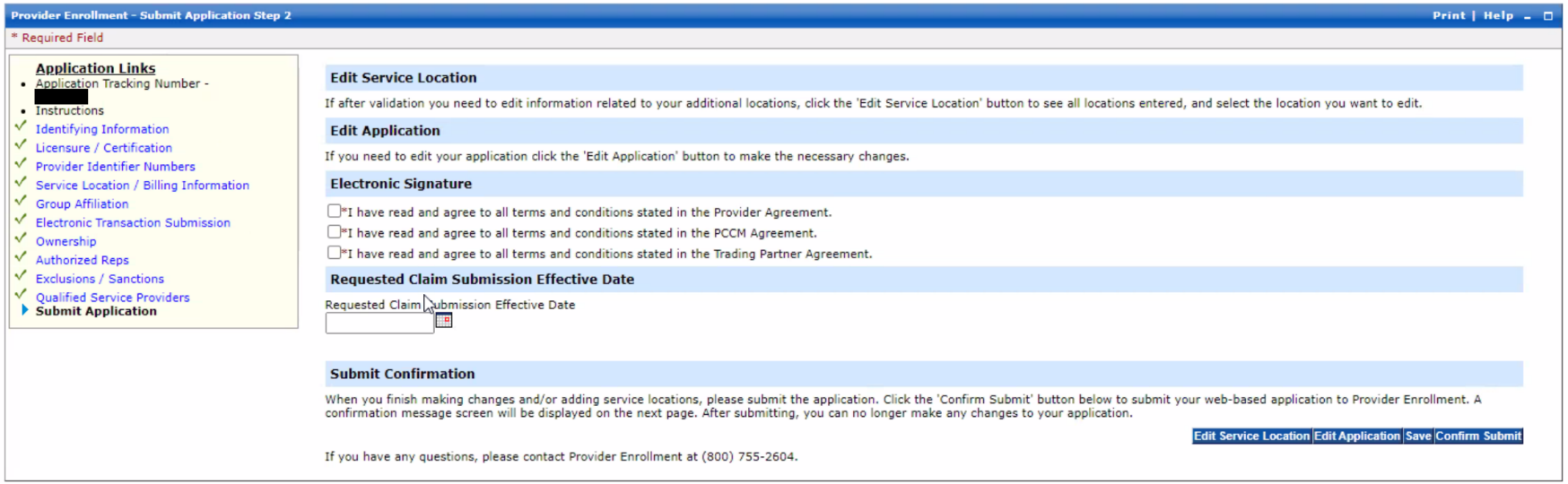
Screen 10 – Submit Application

- Registration for Web Access is optional. If the system does not accept the User ID entered, it should give suggestions. If you do not register before submitting the application, you will need to register after the application is approved. See the "Web Access Registration" section of this guide for more information on registering after the application is approved.

Created 8/24/2017
Revised 4/28/2021

Click "Save"
Click "Validate"

Screen 12: Submit Application Step 2



Screen 12: Submit Application Step 2 – Application Guide Notes

Screen 11

- Claim Submission Effective Date.
    1. This will be the date your enrollment with North Dakota Medicaid is effective.
    2. Claims with dates of service before the Claim Submission Effective Date will deny.
    3. This date will not be changed after the application is approved.
    4. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a complete application packet is received.
    5. 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

    Please note: The Department has a 1 year timely filing policy; claims not submitted and received by ND Medicaid within 1 year from the date of service will deny and not pay.

Click “Save”
Click “Confirm Submit”

If everything is completed, you will be taken to the submission confirmation page.

PDF Forms for 1915(i) providers Group Provider Enrollment

List of PDF Forms for 1915(i) Providers Enrollment

1. **Coversheet for Fax/Email**
2. **Group Application Checklist** *(the document with the list itself)*
3. *IF YOU ARE ENROLLING MORE THAN ONE LOCATION:* **List of Service Locations**
4. **W-9**
5. *IF YOUR AGENCY IS NOT TAX EXEMPT:* **CP 575/147C**
6. *IF YOUR AGENCY IS TAX EXEMPT:* **IRS Tax Exempt Letter**
7. **Group Attestation** *(located within the Group Application Checklist PDF)*
8. **NPI Printout from the NPPES Website**
9. **SFN 661: Electronic Funds Transfer**
   a. **Bank Letter/Voided Check**
10. *IF YOUR AGENCY IS OUT-OF-STATE:* **SFN 509: Out of State/Out of Network Enrollment Clarification**
11. **SFN 1168: Ownership/Controlling Interest and Conviction Information**
12. **SFN 615: Medicaid Program Provider Enrollment**

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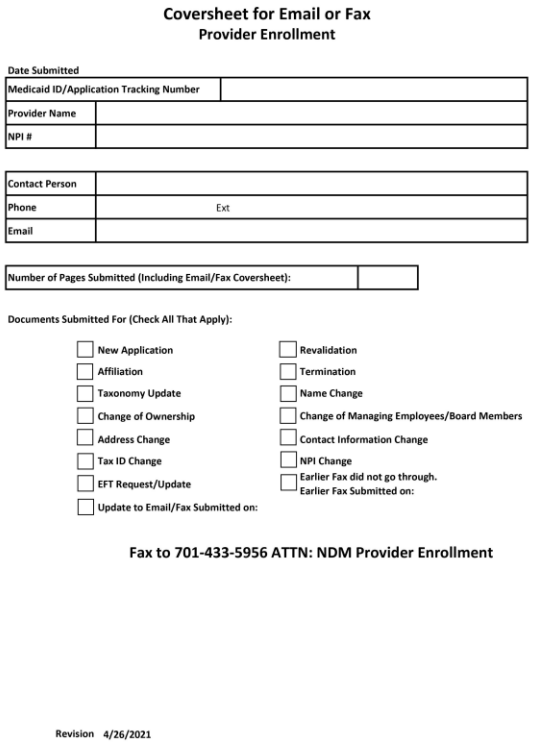
1. Coversheet for Fax/Email

REQUIRED

Notes:

- Application Tracking # comes from the ND MMIS Web Portal.
- Be sure to return to this at the end to enter the correct number of pages submitted.
- Select “New Application.”



Coversheet for Email or Fax
Provider Enrollment

Date Submitted

Medicaid ID/Application Tracking Number	
Provider Name	
NPI #	

Contact Person	
Phone	Ext
Email	

Number of Pages Submitted (Including Email/Fax Coversheet):	

Documents Submitted For (Check All That Apply):

- ☐ New Application
- ☐ Affiliation
- ☐ Taxonomy Update
- ☐ Change of Ownership
- ☐ Address Change
- ☐ Tax ID Change
- ☐ EFT Request/Update
- ☐ Update to Email/Fax Submitted on:
- ☐ Revalidation
- ☐ Termination
- ☐ Name Change
- ☐ Change of Managing Employees/Board Members
- ☐ Contact Information Change
- ☐ NPI Change
- ☐ Earlier Fax did not go through. Earlier Fax Submitted on:

Fax to 701-433-5956 ATTN: NDM Provider Enrollment

Revision 4/26/2021

2. Group Application Checklist – Page 1/2

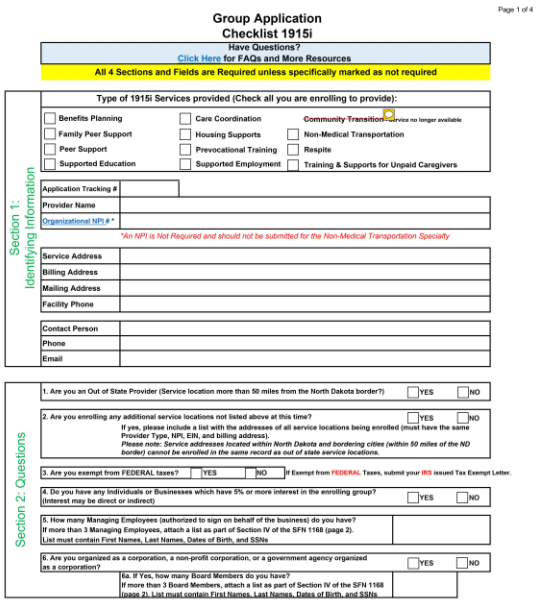
REQUIRED

Notes:

- Select the services your agency wishes to provide for 1915(i)
- Application Tracking # comes from the ND MMIS Web Portal.

Accessed via

[1915i-checklist-attestations-pe.pdf (nd.gov)]



Page 1 of 4

Group Application Checklist 1915i

Have Questions?
Click Here for FAQs and More Resources
All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Type of 1915i Services provided (Check all you are enrolling to provide):

- Benefits Planning
- Care Coordination
- Community Transition (service no longer available)
- Family Peer Support
- Housing Supports
- Non-Medical Transportation
- Peer Support
- Prevocational Training
- Respite
- Supported Education
- Supported Employment
- Training & Supports for Unpaid Caregivers

Application Tracking #	
Provider Name	
Organizational NPI # *	

*An NPI is Not Required and should not be submitted for the Non-Medical Transportation Specialty

Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

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? YES NO
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).
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.

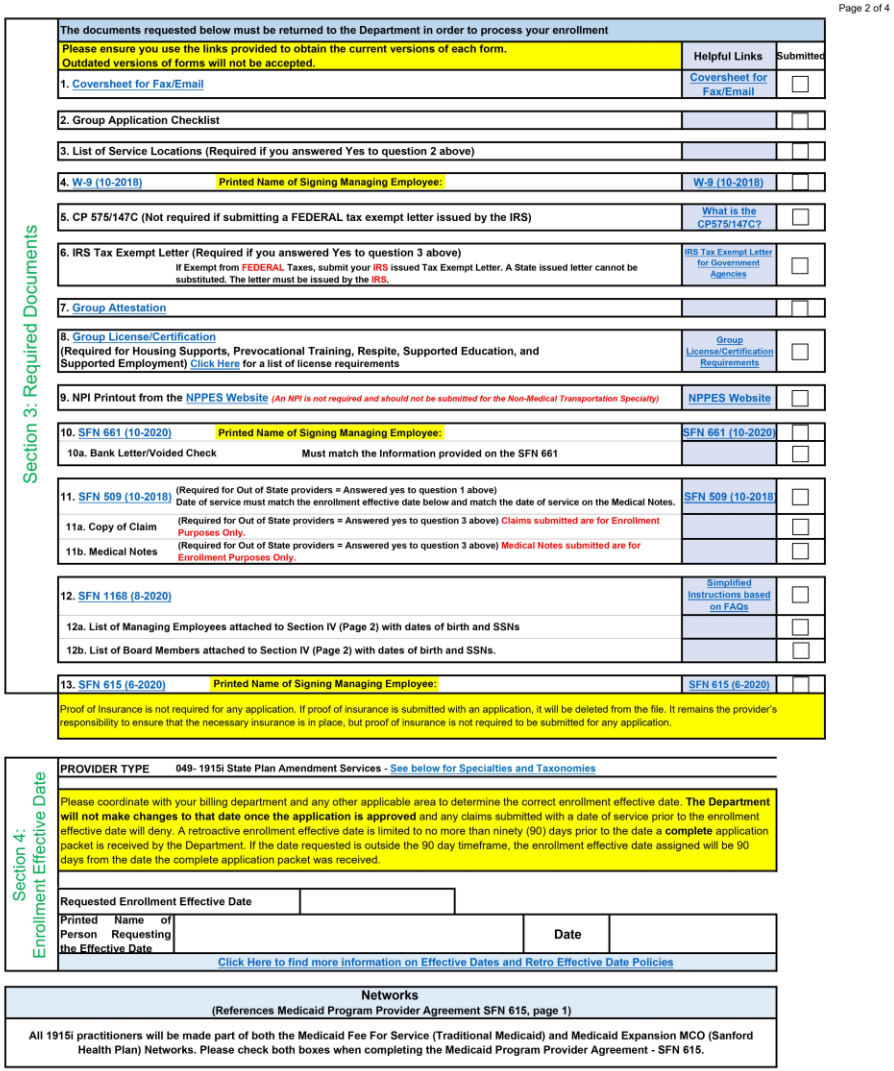
3. Are you exempt from FEDERAL taxes? YES NO If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

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 IV 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 IV of the SFN 1168 (page 2). List must contain First Names, Last Names, Dates of Birth, and SSNs

2. Group Application Checklist – Page 2/2 **REQUIRED**



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**	**Submitted**
1. Coversheet for Fax/Email	Coversheet for Fax/Email	☐
2. Group Application Checklist		☐
3. List of Service Locations (Required if you answered Yes to question 2 above)		☐
4. W-9 (10-2018) **Printed Name of Signing Managing Employee:**	W-9 (10-2018)	☐
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	☐
6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	☐
7. Group Attestation		☐
8. Group License/Certification (Required for Housing Supports, Prevocational Training, Respite, Supported Education, and Supported Employment) Click Here for a list of license requirements	Group License/Certification Requirements	☐
9. NPI Printout from the NPPES Website *(An NPI is not required and should not be submitted for the Non-Medical Transportation Specialty)*	NPPES Website	☐
10. SFN 661 (10-2020) **Printed Name of Signing Managing Employee:**	SFN 661 (10-2020)	☐
10a. Bank Letter/Voided Check **Must match the Information provided on the SFN 661**		☐
11. SFN 509 (10-2018) (Required for Out of State providers = Answered yes to question 1 above) Date of service must match the enrollment effective date below and match the date of service on the Medical Notes.	SFN 509 (10-2018)	☐
11a. Copy of Claim (Required for Out of State providers = Answered yes to question 3 above) Claims submitted are for Enrollment Purposes Only.		☐
11b. Medical Notes (Required for Out of State providers = Answered yes to question 3 above) Medical Notes submitted are for Enrollment Purposes Only.		☐
12. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	☐
12a. List of Managing Employees attached to Section IV (Page 2) with dates of birth and SSNs		☐
12b. List of Board Members attached to Section IV (Page 2) with dates of birth and SSNs.		☐
13. SFN 615 (6-2020) **Printed Name of Signing Managing Employee:**	SFN 615 (6-2020)	☐

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

PROVIDER TYPE 049- 1915i State Plan Amendment Services - See below for Specialties and Taxonomies

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.

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

Networks (References Medicaid Program Provider Agreement SFN 615, page 1)
All 1915i practitioners will be made part of both the Medicaid Fee For Service (Traditional Medicaid) and Medicaid Expansion MCO (Sanford Health Plan) Networks. Please check both boxes when completing the Medicaid Program Provider Agreement - SFN 615.

CSH

3. List of Service Locations

POSSIBLE

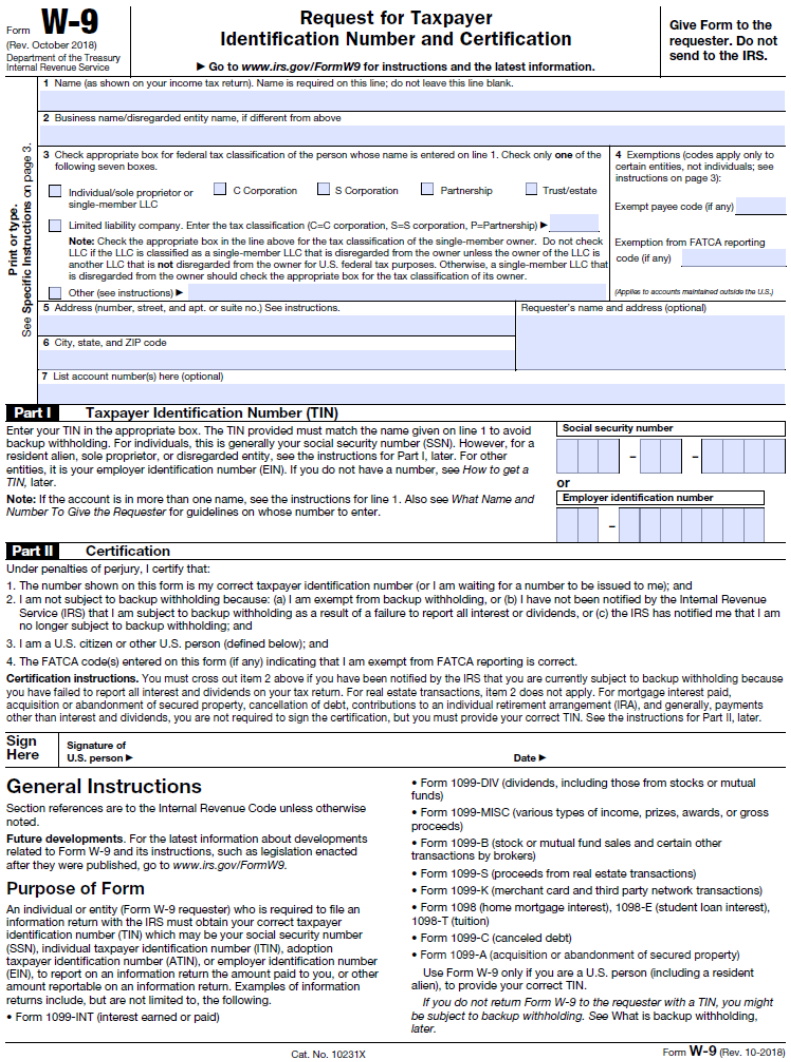
Notes:

- If your agency is enrolling more than one service location, you must include a list with the addresses of all service locations being enrolled. These locations must have the same Provider Type, NPI, EIN, and billing address.
- The Group Application Checklist includes the following note: “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.”

4. W-9

REQUIRED

Accessed via https://www.irs.gov/pub/irs-pdf/fw9.pdf



Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number ___ - ___ - ____

or

Employer identification number __ - _____

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

5. CP 575/147C or 6. IRS Tax Exempt Letter

REQUIRED – you must submit either 5 or 6

Notes:

- 5. CP 575/147C is required for agencies that are **not** tax exempt.
  - CP 575 is an IRS-issued form that confirms that your agency has been granted an Employer Identification Number (EIN).
  - A 147C is an IRS-issued EIN verification letter.
- 6. IRS Tax Exempt Letter is required for agencies that are tax exempt.
  - You cannot use a State-issued tax exempt letter.

7. Group Attestation

REQUIRED

Located within the Provider Enrollment Checklist PDF

GROUP PROVIDER ATTESTATION
1915i SERVICES

_____ _____
Provider Name (printed) NPI

As an entity enrolling to provide 1915i services under the North Dakota Medicaid Program, I attest that I understand and will adhere to all 1915i state and federal standards and requirements as outlined in the North Dakota Medicaid State Plan, including, but not limited to the following:

- ☐ All individual practitioner providers of services meet required qualifications.
- ☐ All individual practitioner providers of services have required competencies.
- ☐ All services provided will be within the scope of practice of the individual provider.
- ☐ Will conduct training per state policies/procedures.
- ☐ Will adhere to all 1915(i) standards and requirements.
- ☐ Required policies are available for NDDHS review.

_____Provider Facility/Organization Name

_____Street Address

_____City, State, Zip Code

_____ _____
Signature of Authorized Representative Date

9. NPI Printout from the NPPES Website

REQUIRED

Notes:

Download from the NPPES website. The file should resemble the one shown.

NPPES
National Plan & Provider Enumeration System

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

PDF Generated by:	Submitted on:	Tracking ID:

Section 1: BASIC INFORMATION

NPI:	
Entity Type:	
Print Date:	
Enumeration Date:	
Certification Date:	

Section 2: PROFILE

Organization Name (includes Groups, Corporations and Partnerships)	
Employer Identification Number(EIN) XX-XXX	Organization Name(Legal Business Name)
Is the organization a subpart?	

Section 3: BUSINESS ADDRESSES AND OTHER INFORMATION

Business Mailing Address Information		
Business Mailing Address:		
Business Telephone number	Extension	Business Fax Number
Primary Practice Location Address Information		
Primary Practice Location Address		
Business Telephone number	Extension	Business Fax Number

Primary Taxonomy Code				
Taxonomy Code	Taxonomy Type	Group Type	License Number	State Issued

CSH

10. SFN 661: Electronic Funds Transfer

REQUIRED

Notes:

SFN 661 sets your agency up for Electronic Funds Transfer from DHS.

This form is essential to ensure your agency can bill for services.

ELECTRONIC FUNDS TRANSFER (EFT)
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 661 (5-2021)

Clear Fields

PRIVACY STATEMENT: The Privacy Act of 1974 (P.L. 93-579, Section 7) requires that the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

The Department of Human Services has the capability of automatic direct deposit of payments. If you are interested in utilizing this service, we will need additional information to assist in providing you with a prompt, accurate payment. An authorization for direct deposit and a W9 are needed.

Please fill this form out accurately and completely. For account verification, attach a voided check, deposit slip, or documentation from your financial institution with both routing and account numbers. Send this along with a W9 form and return to the address below. If you have questions regarding your account number or bank routing number, please contact your bank or financial institution for assistance in obtaining these numbers.

Once you have been enrolled for electronic transfer of funds you will not receive a check or deposit slip with the Remittance Advice (R/A). Please inform your bookkeeping personnel of this to avoid unnecessary telephone calls to the department. The acronym "ACH" will appear in place of the check number in the upper left hand corner of the R/A indicating an automatic check deposit.

If you have questions or need more information, contact Noridian Healthcare Solutions Email:
NDMedicaidEnrollment@noridian.com

Staple voided check, dep

I authorize THE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES and the financial institution named below to initiate deposits to the checking account listed. This authority will remain in effect until I notify the department in writing to cancel this authority, and allow the financial institution a reasonable amount of time to act upon the cancellation.

Name of Financial Institution		Telephone Number	
Address of Financial Institution	City	State	ZIP Code
Provider Name		Telephone Number	
Provider Address	City	State	ZIP Code
Signature			Date

10a. Bank Letter/Voided Check

REQUIRED

Notes:

- You must submit a bank letter or voided check along with SFN 661.

11. SFN 509: Out of State/Out of Network Enrollment Clarification

POSSIBLE

Notes:

Required if your agency is located outside of North Dakota.

You must already have at least one client who is eligible for billing North Dakota Medicaid for services.

OUT OF STATE/OUT OF NETWORK ENROLLMENT CLARIFICATION
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 509 (5-2021)

Clear Fields

Medical Services has received a request from your facility to become a North Dakota Medicaid Provider. Before your enrollment can be processed, you will need to answer the questions below. Out of state or network facilities must have at least one Medicaid or Medicaid Expansion-eligible recipient they will be billing North Dakota Medicaid for services to be or already rendered.

Patient/Recipient Name	Medicaid ID or MCO ID Number	Date of Birth

Address

City	State	ZIP Code

Brief Description and Circumstances of Services To Be or Already Rendered (this must be completed). *

Referring Physician	Date of Service

Name of Facility Enrolling

12. SFN 1168: Ownership/Controlling Interest and Conviction Information

OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION
DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1168 (8-2020)

Clear Fields

The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is mandatory for participation in this program by the Centers for Medicare and Medicaid Services, Department of Health and Human Services. (Citation: 42 CFR 455.104, 455.105, and 455.106) [to participate in the North Dakota Medical Assistance Program (Medicaid) as mandated.] Failure to provide the social security number may result in a delay in processing the application. Disclosure must be made at the time of enrollment or contracting with the Department at time of survey, or within 35 days of a written request from the Department. Any change in ownership shall be reported within 35 days after any change.

I. Identifying Information

The address for corporate entities must include, as applicable, primary business address, every business location, and PO Box address.

Legal Name (Must Match Line 1 of W-9)	Doing Business As (Must match Line 2 of W-9)		
Service Address (required)	City	State	ZIP Code
Mailing Address (required)	City	State	ZIP Code
Billing Address	City	State	ZIP Code
List any PO boxes and corresponding address information associated with this facility		Facility Telephone Number (required)	
FAX Number	ND Medicaid Provider Number	NPI Number	E-Mail Address (required)

II. Direct/Indirect Ownership Information - All Owners with 5% or more Ownership - Per CFR 42 CFR 455.436

Any Owner (Individual or Company) with 5% or more Ownership must be listed:
-Individual as an Owner - List your Social Security Number (SSN) and birth date
-Company as an Owner - List the Tax Identification Number (TIN) of the company that is an owner
-No Ownership: The group that is enrolling/enrolled would be considered its own owner and that information should be listed here.
-For providers enrolled with Medicare and Medicaid, any discrepancies noted in 5% or more ownership will be reported to Medicare.

Name	% Ownership	Relationship	SSN/TIN (required)	Date of Birth (required for individual)
Physical Address (required)		City	State	ZIP Code
Billing Address		City	State	ZIP Code
List Any PO Box Information		City	State	ZIP Code
Name	% Ownership	Relationship	SSN/TIN (required)	Date of Birth (required for individual)
Physical Address (required)		City	State	ZIP Code
Billing Address		City	State	ZIP Code
List Any PO Box Information		City	State	ZIP Code
Name	% Ownership	Relationship	SSN/TIN (required)	Date of Birth (required for individual)
Physical Address (required)		City	State	ZIP Code
Billing Address		City	State	ZIP Code
List Any PO Box Information		City	State	ZIP Code
Additional ownsers attached? ☐ Yes ☐ No				

REQUIRED

Notes:

- The information requested on this form is mandatory to comply with program guidelines set by the Centers for Medicare and Medicaid Services, Department of Health and Human Services.
- Definitions are included on the last two pages of the form.
- Instructions from DHS are available here.
- If you have too many owners for one page, attach an additional page.
- If you have additional managing employees/control interests, attach an additional page.
- If you have additional ownership/controlling interest information, attach an additional page.
- If you have additional conviction information, attach an additional page.

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13. SFN 615: Medicaid Program Provider Enrollment

MEDICAID PROGRAM PROVIDER AGREEMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 615 (Rev. 6-2020)

Agreement between the North Dakota Department of Human Services, hereinafter referred to as "the Department" and:

Provider:	NPI:	Medicaid Provider Number	
Mailing Address:	City:	State:	ZIP Code:

hereinafter referred to as "Provider".

1. Participation. As a condition to participation in the North Dakota Medicaid Program, the Provider agrees to submit true, accurate and complete claims for payment in the manner prescribed by the Department. The Department agrees to pay the Provider for services rendered to persons who are eligible for such services under the rules and regulations for the North Dakota Medicaid Program with payment to be in accordance with the payment structure established by the Department and other programs for which payments are made through the same system.

I wish to participate in (check all that apply):

☐ Medicaid Fee For Service ☐ PACE ☐ Medicaid Expansion MCO (Sanford Health Plan)

Selecting any of the above managed care organization (MCO) boxes (PACE or Sanford Health Plan) does not automatically enroll a provider to render or bill services for the MCO. As all benefits and claims are administrated by the MCO, in order to provide and bill these MCO services, all providers must be contracted directly with the applicable MCO.

2. Compliance. As a condition to participation in the North Dakota Medicaid Program, the Provider agrees that it will comply with all applicable provisions of statute, rules, and federal regulations governing the providing of healthcare and reimbursement of services and items under Medicaid in North Dakota, including the current applicable Medicaid Provider Handbook and any instructions contained in provider information releases or other program notices. The Provider specifically agrees that it is required to comply with:

Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed thereunder by regulation of the Department of Health and Human Services (45 CFR Part 80) to the end that no person shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the provider receives federal financial participation from the state agency; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement;

The Health Insurance Portability and Accountability Act of 1996, 45 CFR parts 160 and 164;
The Age Discrimination Act of 1975, 45 CFR parts 90 and 91;
The Americans with Disabilities Act of 1990, 42 USC section 1201 et. seq.;
The North Dakota Human Rights Act of 1983, NDCC Chapter 14-02.4;
The Social Security Act, section 1902(a)68);

Submitting the PDF Forms

- After completing these forms, you must submit them to ND Medicaid Provider Enrollment via **secure** email, fax, or mail to:
  - **Email:** NDMedicaidEnrollment@Noridian.com (please note: all content will be automatically encrypted)
  - **Fax:** (701) 433-5956 ATTN: NDM Provider Enrollment
  - **Mail:** Noridian Healthcare Solutions
    ATTN: ND Medicaid Provider Enrollment
    PO Box 6055
    Fargo, ND 58108-6055

Break out rooms Next steps for your team

- Whose gathering documents
- Whose reviewing?
- Whose submitting?
- What other tasks need to be added to the work plan?

Up Next:

- Thursday, Oct.27th
- 10-11 am CT

Q&A on Medicaid Academy and Provider Enrollment

Session 2: Participant Enrollment

- Tuesday, Nov. 1st
- 2-4 pm CT

CSH

THANK YOU!

stay connected

csh.org