

# 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.



**WELCOME  
TO  
THE  
NORTH  
DAKOTA  
MEDICAID  
ACADEMY**



# Opening Remarks

NORTH  
**Dakota** | Human Services  
Be Legendary.™

NORTH  
**Dakota** | Behavioral Health  
Be Legendary.™  
HUMAN SERVICES



# 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.

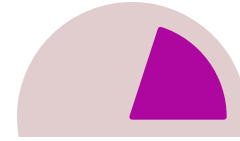
Then, turn off your Arrow by clicking on the **Arrow**  again.

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

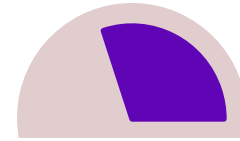
**Haven't yet started** the  
agency application



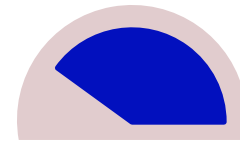
**Started** but haven't submitted  
the agency application



**Submitted** the agency  
application



**Asked to make revisions** to  
the application



**Approved** to provide services



# Medicaid Academy Schedule

Topic	Date	Tools
<b>Orientation and Provider Enrollment</b>	<b>10/25/22</b>	<b>Provider Enrollment Guide</b>
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	

# 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



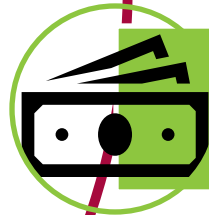
Your  
Team  
includes:



Executive Lead



Program Lead



Fiscal Lead



Quality Lead

# 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.

# Once Academy Ends

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

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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



# 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.

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

Medicaid Academy Team Implementation Work Plan Template\_SAMPLE - Excel

File Home Insert Page Layout Formulas Data Review View Add-Ins ACROBAT Tell me what you want to do...

Cut Copy Paste Format Painter Clipboard Font Alignment Number Styles

C9 X ✓ fx Not started

Medicaid Academy Team Implementation Work Plan by Month Example			Year 1													
Task	Responsible	Status	1	2	3	4	5	6	7	8	9	10	11	12	1	2
<b>Understand our Total Cost of Care</b>	ED, MM, Finance															
Train managers and staff on time study	Joyce	Complete	█													
Conduct time study	Carlos & team	Complete		█												
Analyze time study & summarize trends: what percent of our current activities might be reimbursable in the future?	Joyce & Carlos	In progress			█											
Complete Services Budget Tool 2.0	Carlos & Finance	In progress				█										
Determine minimum FFS rate that would cover our costs	Joyce & Finance	Not started					█									
<b>Develop processes for tracking client Medicaid eligibility and enrollment</b>	MM & QI															
Pull income records, determine eligibility by income & by disability	Carlos	In progress				█	█	█								
Identify what % of current clients have active Medicaid and what staff processes exist to support Medicaid enrollment	Monique & Carlos	In progress				█	█	█								
Connect with MCOs for coordination	Joyce	In progress				█	█	█	█							

Work Plan Codes

Ready

Type here to search

[Work plan template](#)

# 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

## Preliminary Preparation:

- Preparing your agency, staff and residents
- Designate a lead staff person on this transition

If you do not have one, get an National Provider Identifier or NPI number

## Submit documentation to DHS that includes:

- W9
- Business License
- Any licenses or certifications required by DHS

Receive a letter from ND DHS that will include your Medicaid Provider ID. That number is needed on all claims.

Start Delivering services and billing

# Two Types of Provider Enrollment

## Group Enrollment

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

## Individual Enrollment

enrolling each  
provider (Direct  
Services Staff) at  
your agency

# Steps for 1915(I) Provider Enrollment

## 1915(i) Provider Enrollment

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

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

- 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>

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



\* Required Field

### Become a Provider

Enroll to become a Provider by completing the appropriate online entry forms. An individual provider submitting claims to the State of North Dakota will be reported as income under your SSN to the IRS. A group provider submitting claims to the State of North Dakota will be reported as income under the groups' Employer Identification Number (EIN) to the IRS. If you need assistance, please contact Provider Enrollment at (800) 755-2604 during business office hours from Monday to Friday 8 am - 5:00 pm CST.

[FAQ](#)

[Instructions](#)

[Group Provider Enrollment](#)

[Individual Provider Enrollment](#)

[Download a PDF Provider Enrollment Package](#)

[Request a Provider Enrollment Package in the Mail](#)

### Become a Trading Partner

If you would like to become Trading Partner (EDI) to exchange business information electronically with North Dakota, you can do so by completing an application on line. if you have any questions regarding the application process, please contact Provider Enrollment at (800) 755-2604 during business office hours from Monday to Friday, 8am -5pm CST.

[FAQ](#)

[Instructions](#)

[Trading Partner Enrollment](#)

### Application Status

To check the status of your North Dakota Provider or Trading Partner Application, use your Application Tracking # and click the SUBMIT button.

\*Application Tracking #

### Recall Provider Application

To recall an application that you have partially completed, enter your Application Tracking Number, and SSN / EIN and click the SUBMIT button.

\*Application Tracking #

\*SSN/EIN

### Recall Trading Partner Application

To recall an application that you have partially completed, enter your Application Tracking Number and SSN / EIN and click the SUBMIT button.

\*Application Tracking #

\*SSN/EIN

# Provider Enrollment Instructions



Home

Program ▶

Member ▶

Provider ▶

Documentation ▶

Directories ▶

## Group Provider Enrollment Instructions

Print | Help

\* Required Field

### Application Links

#### ▶ Instructions

- [Agreement](#)

### Group Provider Enrollment Instructions

- If you are applying for both an individual provider number and a group provider number, you must complete a separate application for each number.
  - For all date fields, use the date format (mm/dd/yyyy) unless otherwise indicated.
  - Complete all areas of the application, unless otherwise indicated.
  - After completing each page of your application, click the "Continue" button to proceed through the application process.
  - If additional information is necessary to complete the application please attach the necessary documents to the identifying cover page that will be provided at the end of the application.
- This application is for a group practice or facility. Please enroll using your Employer Identification Number (EIN). If you are enrolling with a Social Security Number (SSN), then you must complete the Individual Enrollment Application.

[Continue>>](#) [Cancel](#)



# Provider Enrollment Acknowledgement



\* Required Field

**Application Links**

- [Instructions](#)
- [Agreement](#)

Please **ACCEPT** or **DECLINE** this participation agreement.

**Provider Acknowledgement**

- I attest that the following information is true and correct to the best of my knowledge. Providing false information may be the basis for the North Dakota Department of Human Services refusing or revoking any provider agreements.

# Screen 1: Identifying Information

## Application Links

- Application Tracking Number -
- Instructions
- ✗ Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location / Billing Information
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Authorized Reps
- Exclusions / Sanctions
- Qualified Service Providers

## Help

### Group Name

The name associated with the EIN you enter must match the legal name you have given on your IRS form W9.

### EIN:

Enter as 9 digits with or without dashes.

### Date:

MM/DD/YYYY or click the Calendar icon to choose a date. End Date should be greater than Begin Date.

### Current/Previous ND Provider #:

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

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



## Group Information

\*Group Organization Name  \*Years Doing Business Under this name

? Have you ever used a different Doing Business As (DBA) Name?  Yes  No

## Tax Reporting Information

? \*Legal Name  \*EIN

\*Begin Date   \*End Date  

## Current/Previous ND Provider #

Please enter your current and/or previous ND provider numbers.

### Previous ND Provider #

[Add Previous ND Provider #](#)

ND Provider # 

## Non Profit Organization Tax Exempt Status

Is this business listed under tax exempt status?  
 Yes  No

Please send a copy of your IRS issued exemption.

[Continue>>](#) [Save](#) [Reset](#) [Exit Application](#)

# 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

**Certification** Print |

field

**ation Links**

ion Tracking Number -

ions

ing Information

re / Certification

Identifier Numbers

Location / Billing Information

ffiliation

ic Transaction Submission

hip

sed Reps

ns / Sanctions

d Service Providers

**Type**

ovider Type from the available list.

**:/Certification, Specialty &**

Y:

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n, and Save the form. Click

on an existing row to update or

row.

Y:

D digits/alphas characters.

M/DD/YYYY, MM-DD-YYYY or

r or click the Calendar icon to

late. End or Expiration Date should

than Begin or Effective Date.

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**ontinue** button to move onto the

If you choose to **Exit Application**,

e and note the Tracking Number or

age so you can make updates to

ation at another time.

onal Enrollment Help, click the **Help**

blue bar at the top of this form.

**Provider Type**

\*Provider Type

1915i State Plan Amendment Services ▼

**Licensure and Certification - Section 2**

**Licensure and Certification List** Add Licensure / Certific

License Number	Certification #	State	Licensing Agency	Effective Date	Expiration Date
DUM00000		North Dakota	<a href="#">Other</a>	06/01/2021	12/31/9999

1 - 1 of 1

**Board Certified Specialty List**

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

**Specialty List** Add Spe

Specialty	Provider Type	Certification #	State	Board name	Begin Date	End Date
<a href="#">Housing Supports</a>	<a href="#">1915i State Plan Amendment Services</a>	00000	North Dakota	Other	06/01/2021	12/31/9999

1 - 1 of 1

**Taxonomy**

**Taxonomy Code** Add Taxo

Taxonomy	Begin Date	End Date
<a href="#">251S00000X</a>	06/01/2021	12/31/9999

1 - 1 of 1

[Continue>>](#) [Save](#) [Reset](#) [Exit App](#)

# 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.

# Screen 3: Provider Identifier Numbers

\* Required Field

**Application Links**

- Application Tracking Number -
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers**
  - Service Location / Billing Information
  - Group Affiliation
  - Electronic Transaction Submission
  - Ownership
  - Authorized Reps
  - Exclusions / Sanctions
  - Qualified Service Providers

**Help**

**NPI, DEA, Medicare, and Medicare History**  
To add NPI, DEA, Medicare and/or Medicare History information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**NPI**  
Enter as 10 digits.

**DEA**  
Enter as 2 alphas followed by 7 numeric digits.

**NCPDP**  
Enter as 7 digits.

**Medicare**  
Select at least one Program for each Medicare entry.

**Medicare History**  
Enter the required information for former Medicare Carriers/Intermediaries.

**Date**  
MM/DD/YYYY, or click the Calendar icon to choose a date. End Date should be greater than Begin or Effective Date.

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

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

**Provider Identifier Number- Section 3**

**National Provider Identification (NPI)**

[Add NPI](#)

NPI

1 - 1 of 1

**NCPDP**

[Add NCPDP](#)

NCPDP

\*Are you or have you ever been enrolled as a Medicaid Provider in another State?  
 Yes  No

**Drug Enforcement Agency (DEA)**

[Add DEA Number](#)

DEA #

**Coordination of Benefits Agreement (COBA) - Section 3**

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

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

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

**Medicare Numbers**

[Add Medicare](#)

Medicare Numbers	Medicare Program	Begin Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Medicare History**

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

[Add History](#)

Medicare #	Carrier/Intermediary Name	Medicare Program	Begin Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

# 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.

8

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)

Service
Print | Help

**\* Required Field**

**Application Links**

- Application Tracking Number - [REDACTED]
- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Numbers
- **Service Location / Billing Information**
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Authorized Reps
- Exclusions / Sanctions
- Qualified Service Providers

**Help**

**Service Location**  
Enter the physical address of your primary service location. You may enter additional service locations upon completing the remainder of the information and prior to submitting the application. The Service Location Address may not be a post office box.

**Validate**  
This will provide suggestions based on an official US postal address, you also have the option to override these suggestions.

**Phone, FAX and Contact**  
To add Phone, FAX and/or Contact information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**Service**  
Select the appropriate Gender and Age Range(s) served. If a Language other than English is spoken, select the language from the list, then click the -> to select. If English is not spoken, click the <- to remove it. If the language is not available, please enter it as Other Language. This information will be used for the Public Provider Finder. Answer all required questions by selecting yes or no, additional information may be required if answered Yes.

**Hours of Operation**  
To add Hours of Operation, click the 'Add Hours of Operation' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**Interpretive Services Available**  
To add Interpretive Services Available, click the 'Add Interpretive Service' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**Special Needs**  
To add the Special Needs that your location is equipped to serve, click the appropriate check boxes.

**CLIA**  
To enter CLIA information, click on the plus sign. Click the 'Add CLIA' button. Enter the required information and Save the form. Click

**Service Location Information- Section 4**

\*Physical Address (P.O. Box not accepted)

[REDACTED]

Building, Suite #, etc

[REDACTED]

\*City [REDACTED] \*State North Dakota \*Zip [REDACTED] Zip4 [REDACTED]

\*County [REDACTED]

**Validate Address**

**Location Numbers**

Phone Type	Contact Number
W-Work	[REDACTED]

1 - 1 of 1

**Service Location Contact Person(s)**

Last Name	First Name	MI	Phone	Ext.	Fax #	Cell Phone	Email	Position
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]				[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]				[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]				[REDACTED]	[REDACTED]

1 - 3 of 3

**Add Service location Contact person**

**Service- Section 4**

\*Gender Served:  
 Male  Female  Both

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

\*Languages Supported:  
 Available: Albanian, Arabic, Bangla, Bosnian  
 Selected: English  
 Other Language: [REDACTED]

**Service Area**

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

\*County(s) where service will be provided

Available	Selected
001-Adams 002-Barnes 003-Benson 004-Billings	[REDACTED]

? \*Is this location wheelchair accessible?  
 Yes  No

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

\*TDD/TTY Phone #  
 [REDACTED]

Complete this section with responses that correspond to your agency.



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

Save the form. Click  
row to update or

YYYY or MMDDYYYY or  
to choose a date. End  
ould be greater than

you prefer to receive  
Mailing Address is

you prefer to receive  
Mailing Address is  
Location Address  
Yes. Otherwise,  
ifferent address.

**Transfer (EFT)**  
and have the banking  
answer Yes and enter  
in now. If you do not  
available now, answer  
ollment application. You  
ation at a later time.

you prefer to receive  
Address is identical to  
Address entered above  
Address is identical  
answer Yes.  
to enter a different

Snapshot.

Yes  No  
 Yes  No  
 Yes  No  
 Yes  No

**Hours Of Operation**

Day of Week	Open	Close

**Interpretive Services Available**

Interpretive Services Available

**Special Needs**

Mental Health Disabilities  
 Substance Abuse Disabilities  
 Development Disabilities  
 Behaviorally Disruptive Disabilities  
 Other Disabilities

Deaf/Hearing Impaired Disabilities  
 HIV/AIDS Disabilities  
 Physical Handicapped Disabilities  
 Sexually Aggressive Disabilities  
 Blind/Visually Impaired Disabilities

**Facility Data**

Phone Type	Contact Number

**Mailing Location Contact Person(s)**

Last Name	First Name	MI	Phone	Ext.	Fax #	Email

**Electronic Funds Transfer (EFT) Payments**

Yes  No

**Note:** You can enroll later by using the EFT Enrollment link of the provider portal home page after you have your login credentials.

**Billing Address**

Note: The Billing Address is the location to which mailed payments will be sent.  
 \*Is this billing address the same as the service location?  
 Yes  No

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

Phone Type ▾		Contact Number ▾			
<b>Billing Location Contact Person(s)</b>					
Last Name ▾	First Name ▾	Phone Type ▾	Ext. ▾	Fax # ▾	Pe
<b>Remittance Advice</b>					
*Requested Delivery Media for Remittance Advices(RAs)					
<input type="radio"/> Electronic (835) <input type="radio"/> Web Portal Inbox <input checked="" type="radio"/> Paper					
<b>Note:</b> The provider can only choose one RA option. Your paper RA will be sent to the billing address listed. You can enroll later by using the ERA Enrollment have your login credentials.					
<b>Other Details</b>					
<ul style="list-style-type: none"><li>• Print Suspend: Choose one of the following options if you would like to include your suspended claims on your Remittance Advice</li><li>• RA Sort Indicator: How would you like your Remittance Advice sorted? If none is chosen, the RA will default to the Members last name</li><li>• Bulletin Media : How would you like to receive your bulletins?</li></ul>					
Print Suspend		RA Sort Ind			
<input type="text"/>		<input type="text"/>			



# Screen 4a: EFT Enrollment Form

NORTH DAKOTA MEDICAID Electronic Fund Transfer (EFT) Enrollment Form Print | Help

**\* Required Field**

For Instructions specific to EFT Enrollment click [here](#)

**PROVIDER INFORMATION**

\*Provider Name  Doing Business As (DBA) Name

Provider Address

\*Street  \*City  \*State/Province  \*ZIP Code/Postal Code

**PROVIDER IDENTIFIERS INFORMATION**

\*Provider Federal Tax Identification Number(TIN) or Employer Identification Number(EIN) National Provider Identifier(NPI)

Other Identifier(s)  Assigning Authority

**PROVIDER CONTACT INFORMATION**

Provider Contact Name  Telephone Number  Telephone Number Extension

Email Address  Fax Number

**FINANCIAL INSTITUTION INFORMATION**

\*Financial Institution Name

Financial Institution Address

\*Street  \*City  \*State/Province  \*ZIP Code/Postal Code

\*Financial Institution Telephone Number

\*Financial Institution Routing Number

\*Type of Account at Financial Institution

\*Provider's Account Number with Financial Institution

\*Account Number Linkage to Provider Identifier

National Provider Identifier (NPI)

**SUBMISSION INFORMATION**

\*Reason For Submission

\*Include with Enrollment Submission

**AUTHORIZED SIGNATURE**

\*Printed Name of Person Submitting Enrollment  \*Submission Date  Requested EFT Start/Change/Cancel Date

# 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 Location Information- Section 4

\*Physical Address (P.O. Box not accepted)

Building, Suite #, etc

\*City \*State \*Zip

North Dakota

\*County

Validate Address

Location Numbers

Phone Type Contact Number

Add Service Location Contact Person

Last Name	First Name	MI	Phone	Ext.	Fax #	Cell	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

# 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 will be used to identify Group 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 of the Group, performing providers must be enrolled in the ND Medicaid System as Individual 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 Section 4.

The performing practitioners must enroll separately as ND Medicaid Individual Providers, likewise identifying the Group Providers with which they are affiliated. Individual Providers 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 denied.

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

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contact  
2604

# 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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Created 8/24/2017  
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.

# Screen 6: Electronic Transaction Submission

## Electronic Transaction Submission- Section 6

Providers, who choose to submit claims electronically, must be aware that payment of claims will be from federal and state funds and that any falsification or omissions under Federal and State laws. Further, providers must understand and agree to do the following:

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

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

- North Dakota MMIS Web Portal
- Vendor Software
- Billing Agent/Clearinghouse

# Screen 6: Electronic Transaction Submission – Application Guide Notes

## Screen 6 – Electronic Transaction Submission

- If you use vendor software or have a 3<sup>rd</sup> 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

\* Required Field

**Application Links**

- Application Tracking Number - [REDACTED]
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location / Billing Information
- Group Affiliation
- Electronic Transaction Submission
- Ownership**
- Authorized Reps
- Exclusions / Sanctions
- Qualified Service Providers

**Help**

Answer all of the questions. Additional information will be required if your response is Yes

**Ownership, Managing/Directing, Subcontractor, and Relative:**  
To add Ownership, Managing/Directing, Subcontractor, and/or RelativeEmployee and/or Relative information, click the appropriate 'Add' button. Enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

**Date:**  
MM/DD/YYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.

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

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

Ownership- Section 7

? \*1. How many owners of this applicant have a 5% or more ownership interest in the group?  
Please enter ownership information for each owner included in the number above  
[0] [Add Ownership](#)

Name	Doing Business As (DBA) Name	Effective Date of Ownership	Current ND Provider #
------	------------------------------	-----------------------------	-----------------------

? \*2. Are any of the persons with an ownership or controlling interest in the provider's company related to one another as spouse, parent, child, sibling or household member?  
 Yes  No

? \*3. What is the total number of managing/directing employees for the group?  
Please enter employee information for each employee included in the number entered.  
[1] [Add Employee](#)

Last Name	First Name	MI	Title	Date of Birth
-----------	------------	----	-------	---------------

[Add Employee](#) [Save](#) | [Reset](#) | [Cancel](#)

\*Last Name [REDACTED] \*First Name [REDACTED] MI [REDACTED] Title [Director] \*Date of Birth [REDACTED] \*SSN [REDACTED]

\*State/Country of Birth [REDACTED]

? \*4. Has the managing/directing employee ever had a Medicaid provider number in this or any other state?  
 Yes  No

? \*5. Do any of the members of your immediate family (spouse, parent, child, sibling or household member) have ownership of 5% or greater in a subcontractor to your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/provider has contracted responsibilities of providing medical care to its patients.)  
 Yes  No

[Continue>>](#) [Reset](#) [Save](#) [Exit Application](#)

# 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

Authorized Reps Print | Help

\* Required Field

#### Application Links

- Application Tracking Number -
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location / Billing Information
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Authorized Reps**
- Exclusions / Sanctions
- Qualified Service Providers

#### Authorized Representatives

[Add Authorized Representatives](#)

Last Name	First Name	Middle Initial	Suffix	Begin Date	End Date
-----------	------------	----------------	--------	------------	----------

#### Add Authorized Representatives

[Save](#) | [Reset](#) | [Cancel](#)

Begin Date:  End Date:

\*Last Name:  \*First Name:  Middle Initial:  Title:  Suffix:

Position:

#### Pharmacist In Charge

Last Name:  First Name:  Middle Initial:  Title:

[Continue>>](#) [Save](#) [Reset](#) [Exit Application](#)

#### Help

**Authorized Representatives:**  
To enter Authorized Representatives information, click the 'Add Authorized Representative' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**Date:**  
Enter as MM/DD/YYYY or click the Calendar icon to choose a date. End Date should be greater than Begin Date.

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

If you have any questions, please contact  
Customer Support at (800) 375-3333

# 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

Exclusions / Sanctions Print | Help

\* Required Field

**Application Links**

- Application Tracking Number -
- **Exclusions / Sanctions**
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifiers Numbers
- ✓ Service Location / Billing Information
- ✓ Group Affiliation
- ✓ Electronic Transaction Submission
- ✓ Ownership
- ✓ Authorized Reps
- Exclusions / Sanctions
  - Qualified Service Providers

**Help**

Answer all of the questions. Additional information will be required if your response is Yes.

**Name and Federal Program**  
To add Name and Federal Program information, click the appropriate "Add" button. Enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

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

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

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

**Exclusion / Sanction - Section 7**

7 \*1. Are any of the named owners related to owners of the subcontractor as spouse, parent, child, sibling or household member?  
 Yes  No

7 \*2. Is the group chain affiliated?  
 Yes  No

7 \*3. Is the group operated by a management company or leased in whole or part by another organization?  
 Yes  No

7 \*4. Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5% or more in the group that have been convicted of a criminal offense related to involvement of such individuals, or organization in any of the programs established by Medicare, Medicaid, and State Health Insurance Programs?  
 Yes  No

7 \*5. Are there any directors, officers, agents, or managing employees of the group that have ever been convicted of a criminal offense related to their involvement in such programs established by Medicare, Medicaid, and State Health Insurance Program?  
 Yes  No

7 \*6. Has any family or household member or any person who has ownership or controlling interest in the group, ever been convicted, assessed, or excluded from State or Federal programs due to fraud, obstruction of an investigation or a controlled substance violation?  
 Yes  No

7 \*7. Does the applicant under any name or business identity, have any outstanding overpayments with any state or federal program?  
 Yes  No

7 \*8. Has the applicant ever been convicted of a felony under Federal or State Law?  
 Yes  No

If you have ever had any of the following adverse legal actions imposed or are pending by any federal or state agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed.

**Important:** Attach copy of adverse legal action notification(s).

7 \*9. Administrative Sanction(s)?  
 Yes  No

7 \*10. Professional Board Disciplinary Action(s)?  
 Yes  No

7 \*11. Program Exclusions?  
 Yes  No

7 \*12. Suspension of Payments?  
 Yes  No

7 \*13. Civil Monetary Penalty(s)?  
 Yes  No

7 \*14. Assessment(s)?  
 Yes  No

7 \*15. Program Debarment(s)?  
 Yes  No

7 \*16. Criminal Fine(s)?  
 Yes  No

7 \*17. Restitution Order(s)?  
 Yes  No

7 \*18. Pending Civil Judgment(s)?  
 Yes  No

7 \*19. Pending Criminal Judgment(s)?  
 Yes  No

7 \*20. Judgment(s) Pending under the False Claims Act?  
 Yes  No

[Continue](#) [Reset](#) [Save](#) [Exit Application](#)

# 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

Qualified Service Providers Print | Help - □

**Application Links**

- Application Tracking Number - [REDACTED]
- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Numbers
- ✓ Service Location / Billing Information
- ✓ Group Affiliation
- ✓ Electronic Transaction Submission
- ✓ Ownership
- ✓ Authorized Reps
- ✓ Exclusions / Sanctions
- ▶ **Qualified Service Providers**

**Help**

**Agency Qualified Service Provider:**  
Select a county from the list where service will be provided then click -> to select. If you need to remove a county from the Selected list, select the county then click <- to remove it.

**Agency Qualified Service Provider Global Endorsements:**  
Select an endorsement from the list then click -> to select. If you need to remove an endorsement from the Selected list, select the endorsement then click <- to remove it.

**Qualified Service Provider Questionnaire:**  
Initial all of the items to indicate your understanding and agreement.

**Non-Medical Provider:**  
To enter Medicaid eligible recipient information, click the 'Add Medicaid Eligible Recipients' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

Skip this section.

**Non-Medical Provider (meals, lodging, transportation)**

List your Medicaid eligible recipients.  
You must list at least one recipient to enroll as a provider.

[Add Medicaid Eligible Recipients](#)

Medicaid ID ▾	Last Name ▾	First Name ▾	MI ▾
All Transportation Providers: You are required to submit with your application a copy of your current valid driver's license and proof of insurance.			

[Continue>>](#) [Save](#) [Reset](#) [Exit Application](#)

# 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

Provider Enrollment - Submit Application Step 1 Print | Help - □

\* Required Field

**Application Links**

- Application Tracking Number - [REDACTED]
- ✓ Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Numbers
- ✓ Service Location / Billing Information
- ✓ Group Affiliation
- ✓ Electronic Transaction Submission
- ✓ Ownership
- ✓ Authorized Reps
- ✓ Exclusions / Sanctions
- ✓ Qualified Service Providers
- ▶ **Submit Application**

**Provider Agreement**

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

[Medicaid and Basic Care Assistance Programs Provider Agreement](#)  
[Medicaid Program Provider Agreement](#)  
[Pharmacy Agreement/Medical Assistance Program](#)  
[PCCM Agreement](#)  
[EDI Trading Partner Agreement](#)

**Register for Web Access**

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.  
Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advices.

Yes  No

*Organization Name		*Organization Description	*User ID	
<input type="text"/>		<input type="text"/>	<input type="text"/>	
Prefix	*Last Name	*First Name	MI	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Phone #	Ext	E-mail		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

**Validate Application**

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

Save and then validate.

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

# 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.

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Created 8/24/2017

Revised 4/28/2021

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Click “Save”

Click “Validate”

# Screen 12: Submit Application Step 2

Provider Enrollment - Submit Application Step 2 Print | Help -

\* Required Field

**Application Links**

- Application Tracking Number -
- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Numbers
- ✓ Service Location / Billing Information
- ✓ Group Affiliation
- ✓ Electronic Transaction Submission
- ✓ Ownership
- ✓ Authorized Reps
- ✓ Exclusions / Sanctions
- ✓ Qualified Service Providers
- ▶ **Submit Application**

**Edit Service Location**

If after validation you need to edit information related to your additional locations, click the 'Edit Service Location' button to see all locations entered, and select the location you want to edit.

**Edit Application**

If you need to edit your application click the 'Edit Application' button to make the necessary changes.

**Electronic Signature**

I have read and agree to all terms and conditions stated in the Provider Agreement.

I have read and agree to all terms and conditions stated in the PCCM Agreement.

I have read and agree to all terms and conditions stated in the Trading Partner Agreement.

**Requested Claim Submission Effective Date**

Requested Claim Submission Effective Date

**Submit Confirmation**

When you finish making changes and/or adding service locations, please submit the application. Click the 'Confirm Submit' button below to submit your web-based application to Provider Enrollment. A confirmation message screen will be displayed on the next page. After submitting, you can no longer make any changes to your application.

[Edit Service Location](#) | [Edit Application](#) | [Save](#) | [Confirm Submit](#)

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

# 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**

# 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):

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

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

<input type="checkbox"/> Benefits Planning	<input type="checkbox"/> Care Coordination	<input type="checkbox"/> Community Transition <small>Service no longer available</small>
<input type="checkbox"/> Family Peer Support	<input type="checkbox"/> Housing Supports	<input type="checkbox"/> Non-Medical Transportation
<input type="checkbox"/> Peer Support	<input type="checkbox"/> Prevocational Training	<input type="checkbox"/> Respite
<input type="checkbox"/> Supported Education	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> 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 1: Identifying Information**

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

**Section 2: Questions**



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

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		<a href="#">Coversheet for Fax/Email</a>	<input type="checkbox"/>
2. Group Application Checklist			<input type="checkbox"/>
3. List of Service Locations (Required if you answered Yes to question 2 above)			<input type="checkbox"/>
4. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	<input type="checkbox"/>
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		What is the CP575/147C?	<input type="checkbox"/>
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	<input type="checkbox"/>
7. Group Attestation			<input type="checkbox"/>
8. Group License/Certification (Required for Housing Supports, Prevocational Training, Respite, Supported Education, and Supported Employment) <a href="#">Click Here</a> for a list of license requirements		Group License/Certification Requirements	<input type="checkbox"/>
9. NPI Printout from the <a href="#">NPPES Website</a> (An NPI is not required and should not be submitted for the Non-Medical Transportation Specialty)		NPPES Website	<input type="checkbox"/>
10. SFN 661 (10-2020)	Printed Name of Signing Managing Employee:	SFN 661 (10-2020)	<input type="checkbox"/>
10a. Bank Letter/Voided Check	Must match the information provided on the SFN 661		<input type="checkbox"/>
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)	<input type="checkbox"/>
11a. Copy of Claim	(Required for Out of State providers = Answered yes to question 3 above) <b>Claims submitted are for Enrollment Purposes Only.</b>		<input type="checkbox"/>
11b. Medical Notes	(Required for Out of State providers = Answered yes to question 3 above) <b>Medical Notes submitted are for Enrollment Purposes Only.</b>		<input type="checkbox"/>
12. SFN 1168 (8-2020)		Simplified Instructions based on FAQs	<input type="checkbox"/>
12a. List of Managing Employees attached to Section IV (Page 2) with dates of birth and SSNs			<input type="checkbox"/>
12b. List of Board Members attached to Section IV (Page 2) with dates of birth and SSNs.			<input type="checkbox"/>
13. SFN 615 (6-2020)	Printed Name of Signing Managing Employee:	SFN 615 (6-2020)	<input type="checkbox"/>
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 - <a href="#">See below for Specialties and Taxonomies</a>		
	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 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		
<a href="#">Click Here to find more information on Effective Dates and Retro Effective Date Policies</a>				
<b>Networks</b> (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.				



## 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](http://www.irs.gov/FormW9) for instructions and the latest information.

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

---

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.

<input type="checkbox"/> Individual/sole proprietor or single-member LLC	<input type="checkbox"/> C Corporation	<input type="checkbox"/> S Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Trust/estate
<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►				
<input type="checkbox"/> Other (see instructions) ►				

**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.

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								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> </tr> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td colspan="2"></td> </tr> </table>					-	-		
-	-							
OR								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> </tr> <tr> <td style="text-align: center;">-</td> <td colspan="3"></td> </tr> </table>					-			
-								

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**Part II Certification**

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- 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](http://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.



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:
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#### 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



# 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](mailto:NDMedicaidEnrollment@noridian.com)

<b>Staple voided check, del</b>	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/Voiced Check

### **REQUIRED**

#### Notes:

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





# 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)

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. (Citations: 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 30 days of a written request from the Department. Any change in ownership shall be reported within 30 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 owners 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.

# 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](mailto: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.27<sup>th</sup>**
- **10-11 am CT**

**Q&A on Medicaid  
Academy and  
Provider Enrollment**

**Session 2:  
Participant  
Enrollment**

- **Tuesday,  
Nov. 1<sup>st</sup>**
- **2-4 pm CT**

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# THANK YOU!

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stay connected



[csh.org](http://csh.org)