NORTH Dakota Be Legendary.

Health & Human Services

Home Health Agency (HHA) (025-082)
Group Application Requirements

Type of Application: **Date submitted: _____**

- ☐ **New Application**
- ☐ **Revalidation**
- ☐ **Reactivation**

Section 1: Group Information

Application Tracking # (New Applications only):	
Current Medicaid ID Number (only used for Revalidation and Reactivation):	
Legal Business Name:	
Organization NPI #:	
Service Location:	
Billing Address:	
Mailing Address:	
Facility Phone:	
Contact person / Title:	
Contact phone number:	
Contact email:	

**Only 1 service location may be enrolled per Medicare ID*

1. What is the name and Medicaid ID, Application Tracking Number (ATN), or NPI of the Director or Referring Doctor who will be on your claims as the Attending Physician? *Institutional claims require an attending be enrolled and entered on claims for processing. The attending can be either a medical director or attending/referring doctor. If no attending is included on the claims, or the attending is not enrolled, the claim will deny.

Name: _____ Medicaid ID/ATN/NPI: _____

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2. Are you Medicare enrolled? ☐Yes ☐No
   Is your Medicare record up to date? ☐Yes ☐No

* ***Medicare Enrollment is required***

Medicare ID: _____

Provider Type 025-Agencies
Specialty 082-Home Health Agency
Taxonomy 251E00000X

☐This application is not associated with an emergency service. We are requesting an effective date of
_____.

☐This application is associated with emergent care. We are requesting an effective date of
_____.

*ND Medicaid may consider a retroactive enrollment effective date that exceeds ninety (90) days but not to exceed 365 days from the date of service for situations involving emergent care provided to a member. If the application involves an emergency service, an explanation on why enrollment was not able to be submitted within ninety (90) days from the date of service and medical notes must be sent with the application requirements. If you do not submit this information, a date beyond ninety (90) days of receipt of a completed application will not be approved.

Section 2: Required Documents:

1. Group Application Requirements

2. CP 575 or 147C **(*Not required if submitting a FEDERAL tax-exempt letter issued by the IRS)**

- The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter providers receive from the IRS granting their Employer Identification Number (EIN). The 147C is a replacement letter from the IRS verifying your Legal Business Name and Tax ID. This letter can be used in place of a CP 575. If unable to locate either of these letters, visit Lost or Misplaced Your EIN? | Internal Revenue Service (irs.gov) for direction.

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3. IRS Tax Exempt Letter-501(C3) (*__If Exempt from FEDERAL Taxes__)
   **A State issued letter cannot be substituted. The letter must be issued by the IRS.*
   - For more information, refer to: Governmental Information Letter | Internal Revenue Service (irs.gov)

4. Home Health Agency License

5. CMS Certification Letter

6. Medicare EOB

7. SFN 661 - Electronic Funds Transfer (EFT)
   - Bank letter or voided check. If submitting a bank letter this must be on bank letterhead and include the name on the account (the name must match the Legal Business Name as it is listed on the IRS documentation), account and routing numbers, type of account and be signed by a bank official.

8. SFN 509 - Out of State/Out of Network Enrollment Clarification
   ***__Only required if services are more than 50 miles outside of the ND border and located within the United States__
   - For more information on Out of State services, refer to: **Out-of-state services**

9. SFN 1168 - Ownership/Controlling Interest and Conviction Information
   - List of Managing Employees attached to Section IV (Page 2) with dates of birth and SSNs.
   - List of Board Members attached to Section IV (page 2) with dates of birth and SSNs.

10. SFN 615 - Medicaid Program Provider Agreement
    Must be signed and dated by a Managing Employee

**Submission directions on final page.*

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Application may be submitted by:
Email: NDMedicaidenrollment@noridian.com
Fax: 701-433-5956 ATTN: NDM Provider Enrollment
Mail: Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

For questions concerning Provider Enrollment, please contact (877) 328-7098 (toll-free) or (701) 328-7098. Live support 8 a.m. - 5 p.m. CT, Monday – Friday.