INDIVIDUAL ATTESTATION

TARGETED CASE MANAGEMENT SERVICES TO HIGH RISK PREGNANT WOMEN AND INFANTS

_________________________ Practitioner Name (printed)

_________________________ NPI

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

I have met the following requirement:

(CHECK ALL THAT APPLY):

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

OR

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

OR

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

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

___________________________________ Signature of Enrolling Practitioner

_______________ Date

Provider Facility/Organization to complete:

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

__________________________________Provider Facility/Organization Name
__________________________________Street Address
__________________________________City, State, Zip Code

____ Supervisor Signature

_______________ Date

____ Printed Name of Supervisor

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

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