NORTH Dakota Be Legendary.

Health & Human Services

# INDIVIDUAL ATTESTATION

## TARGETED CASE MANAGEMENT SERVICES TO HIGH RISK PREGNANT WOMEN AND INFANTS

_____ _____

Individual 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 on second page.**

NORTH Dakota Be Legendary.

Health & Human Services

# INDIVIDUAL ATTESTATION

## TARGETED CASE MANAGEMENT SERVICES TO HIGH RISK PREGNANT WOMEN AND INFANTS

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**