INDIVIDUAL ATTESTATION

LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

____________________________ Practitioner Name (printed)

________________________ NPI

Please note that you have requested enrolling as a <u>Case Management</u> 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 requirements:

(CHECK ALL THAT APPLY):

1. ______ I am a Developmental Disabilities program manager

AND

a. _______ I am a Qualified Intellectual Disabilities Professional (QIDP)

OR

b. _______ I have at least 1 year of experience as a Developmental Disabilities Case Manger in the North Dakota Department of Human Services.

I attest that I met the above requirements 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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