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# Medicaid Provider Enrollment

## Individual Provider Enrollment

### Individual Provider Introduction

#### Procedure

Access ND MMIS Web Portal:

<https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment>

The screenshot shows the North Dakota MMIS Web Portal. At the top, there is a navigation bar with links: Home, Program, Member, Provider, Documentation, and Directories. The main content area is titled "Provider Enrollment" and includes a "Print | Help" link. The page is divided into several sections:

- Become a Provider:** This section provides information on how to enroll as a provider, including a link to the "FAQ" and "Instructions". It also includes links for "Group Provider Enrollment", "Individual Provider Enrollment", "Download a PDF Provider Enrollment Package", and "Request a Provider Enrollment Package in the Mail".
- Become a Trading Partner:** This section provides information on how to enroll as a trading partner, including a link to the "FAQ" and "Instructions". It also includes a link for "Trading Partner Enrollment".
- Application Status:** This section allows users to check the status of their North Dakota Provider or Trading Partner Application. It includes a form with a label "\*Application Tracking #" and a "Submit" button.
- Recall Provider Application:** This section allows users to recall an application that they have partially completed. It includes a form with labels "\*Application Tracking #" and "\*SSN/EIN", and a "Submit" button.
- Recall Trading Partner Application:** This section allows users to recall an application that they have partially completed. It includes a form with labels "\*Application Tracking #" and "\*SSN/EIN", and a "Submit" button.

The screenshot shows the North Dakota MMIS Web Portal. The main navigation bar includes links for Home, Program, Member, Provider, Documentation, and Directories. The 'Provider Enrollment' section is active, displaying options for 'Become a Provider', 'Application Status', 'Recall Provider Application', 'Become a Trading Partner', and 'Recall Trading Partner Application'. The 'Individual Provider Enrollment' link is highlighted with a red box.

Step	Action
1.	Click the <b>Individual Provider Enrollment</b> link. <a href="#">Individual Provider Enrollment</a>

The screenshot shows the 'Individual Provider Enrollment Instructions' page. It contains a list of instructions for applying for a provider number. At the bottom of the instructions, the 'Continue>>' button is highlighted with a blue box.

Step	Action
2.	Click the <b>Continue&gt;&gt;</b> button. It is <b>very important</b> to read all on-screen instructions and notes

North Dakota MMIS Web Portal

Feb 1, 2013

Skip Navigation | Contact Us | Help | Search

Home | Program | Member | Provider | Documentation | Directories

Provider Enrollment Agreement

Print | Help

\* Required Field

Application Links

- Instructions
- Agreement

Provider Acknowledgement

Please ACCEPT or DECLINE this participation agreement.

- 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.

Accept Decline

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Step	Action
3.	Click the <b>Accept</b> button. <b>This will take you to the first section of the Enrollment Application: Identifying Information</b> <b>Accept</b>
Step	Action
4.	The next section will take you through how to complete the Identifying Information page. <b>End of Procedure.</b>

# Identifying Information

## Procedure

**Identifying Information- Section 1**

\*Last Name \*First Name MI Suffix Title

\*Date of Birth

\*Gender \*Can information about date of birth and gender be available to clients?  
☐ Male ☐ Female ☐ Yes ☒ No

\*SSN

**Note:** Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.

**Current/Previous ND Provider #**

? Please enter your current and/or previous ND Provider numbers.

**Previous ND Provider IDs** [Add Previous Provider ID](#)

**ND Provider ID #**

**Previous Names**

Have you used any previous names in the past five years?  
☐ Yes ☐ No

Step	Action
1.	Enter the desired information into the <b>Last Name</b> field.
Step	Action
2.	Enter the desired information into the <b>First Name</b> field.
Step	Action
3.	Enter the desired information into the <b>Date of Birth</b> field.
Step	Action
4.	Click the <b>Male or Female</b> option.
Step	Action
5.	Click the <b>Yes or No</b> option for the question "Can information about date of birth and gender be available to clients".
Step	Action
6.	Enter the desired information into the <b>SSN</b> field.

Identifying Information - Section 1

\*Last Name: Smith, \*First Name: Tim, MI: , Suffix: , Title:

\*Date of Birth: 12/15/1960

\*Gender: ☒ Male ☐ Female, \*Can information about date of birth and gender be available to clients? ☒ Yes ☐ No

\*SSN: 505-55-5555

Note: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.

Current/Previous ND Provider #

? Please enter your current and/or previous ND Provider numbers.

Previous ND Provider IDs

ND Provider ID #

Add Previous Provider ID

Previous Names

Have you used any previous names in the past five years?

☐ Yes ☒ No

Previous ND Provider IDs

ND Provider ID #

Add Previous ND Provider IDs

Save | Reset | Cancel

\*ND Provider ID #

Step	Action
7.	Click the <b>Add Previous Provider ID</b> button. By selecting any <b>"ADD"</b> options, additional fields open that need to be completed. <b>Add Previous Provider ID</b>
Step	Action
8.	Enter the desired information into the <b>ND Provider ID #</b> field This is current/previous ND Medicaid numbers. <b>Enter only <u>one</u> Medicaid number.</b>
Step	Action
9.	<b>It is Very Important to always click Save within each additional information window pane</b>
Step	Action
10.	Click the <b>Save</b> link. <b>Save</b>

your IRS form W-9.

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

**SSN**  
Enter as 9 digits with or without dashes

**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

**Previous Names:**  
Answer the question. Additional information will be required if your response is Yes.

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 to 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.

System successfully saved the Information.

**Previous ND Provider IDs** Add Previous Provider ID

ND Provider ID #
000012345


1 - 1 of 1

**Previous Names**

Have you used any previous names in the past five years?

☐ Yes ☐ No

Continue>> Reset Save Exit Application

Step	Action
11.	Click the Previous Names <b>Yes or No</b> option.
Step	Action
12.	Click the <b>Save</b> button. 

**Identifying Information**

**Required Field**  
The Provider Enrollment Details have been saved successfully. Please note your Application Tracking number 124004 for future access to the enrollment Application.

**Application Links**

- Application Tracking Number - 124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**Help**

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

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

**SSN**  
Enter as 9 digits with or without dashes

**Current/Previous ND Provider #**  
To enter your Current and/or Previous ND

**Identifying Information- Section 1**

\*Last Name: Smith, \*First Name: Tim, MI: , Suffix: , Title:   
 \*Date of Birth: 12/15/1960   
 \*Gender: ☒ Male ☐ Female, \*Can information about date of birth and gender be available to clients? ☒ Yes ☐ No   
 \*SSN: 505555555   
 Note: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.

**Current/Previous ND Provider #**  
Please enter your current and/or previous ND Provider numbers.   
Add Previous Provider ID

**Previous ND Provider IDs**

ND Provider ID #
000012345

1 - 1 of 1

**Previous Names**  
Have you used any previous names in the past five years?   
☐ Yes ☒ No

**Previous Names:**  
https://mmis.nd.gov/portals/wps/portal/ut/p/c/hy5JCoNAEEp4gmqN7Ljo...

Step	Action
13.	After selecting SAVE, the application tracking number (ATN) will be displayed at the top of the page. It is important to write this number down and keep it for future reference. The ATN is required when submitting any documentation and/or inquiries to the Department.

**Identifying Information**

**Application Links**

- Licensure / Certification
- Provider Identifier Numbers
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**Help**

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

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

**SSN**  
Enter as 9 digits with or without dashes

**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

**Identifying Information**

\*Date of Birth: 12/15/1960   
 \*Gender: ☒ Male ☐ Female, \*Can information about date of birth and gender be available to clients? ☒ Yes ☐ No   
 \*SSN: 505555555   
 Note: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.

**Current/Previous ND Provider #**  
Please enter your current and/or previous ND Provider numbers.   
Add Previous Provider ID

**Previous ND Provider IDs**

ND Provider ID #
000012345

1 - 1 of 1

**Previous Names**  
Have you used any previous names in the past five years?   
☐ Yes ☒ No

**Buttons:** Continue>> Reset Save Exit Application

**Previous Names:**  
https://mmis.nd.gov/portals/wps/portal/ut/p/c/hy5JCoNAEEp4gmqN7Ljo...



Step	Action
14.	Click the <b>Continue&gt;&gt;</b> button.

**Continue>>**

The screenshot shows the 'Licensure / Certification' page in the North Dakota MMIS system. The left sidebar contains a menu with the following items: 'Application Links' (Application Tracking Number -124004), 'Instructions', 'Identifying Information' (highlighted in red), 'Licensure / Certification', 'Provider Identifier Numbers', 'Service Location', 'Billing', 'Group Affiliation', 'Electronic Transaction Submission', 'Ownership', 'Exclusion / Sanction', and 'Qualified Service Providers'. The main content area is divided into several sections: 'Provider Type' with a dropdown menu, 'Licensure and Certification - Section 2' with a note about entering current licensure information and an 'Add Licensure / Certification' button, 'Board Certified Specialty List' with a note about board certification requirements and an 'Add Specialty' button, and 'Taxonomy' with an 'Add Taxonomy' button. The 'Identifying Information' section is currently active, showing a table with columns for License #, Lic/Cert Agency, Cert #, State, Effective Date, and Expiration Date.

Step	Action
15.	Clicking continue will bring you to the next section to be completed.
Step	Action
16.	The next section will take you through how to complete the Licensure / Certification page. <b>End of Procedure.</b>

## Licensure/Certification

### Procedure

**Provider Type:** Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes: <https://www.bhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

The screenshot shows the North Dakota MMIS Web Portal interface. The main navigation bar includes links for Home, Program, Member, Provider, Documentation, and Directories. The current page is titled 'Licensure / Certification' and features a 'Required Field' section with a dropdown menu for 'Provider Type', which is highlighted with a red box. Below this, there is a 'Licensure and Certification - Section 2' section with a note about entering information for current licensure and/or certification. A table titled 'Licensure and Certification List' is visible, with columns for License #, Lic/Cert Agency, Cert #, State, Effective Date, and Expiration Date. There is also a 'Board Certified Specialty List' section with a note about entering information for all specialties for which the user is board certified or eligible. A table titled 'Specialty List' is also present, with columns for Specialty, Provider Type, Certification #, State, Board Name, Begin Date, and End Date.

Step	Action
1.	Click the <b>Provider Type</b> list.
Step	Action
2.	Select the <b>Appropriate</b> provider type.

**Licensure / Certification**

**Required Field**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification**
  - Provider Identifier Numbers
  - Service Location
  - Billing
  - Group Affiliation
  - Electronic Transaction Submission
  - Ownership
  - Exclusion / Sanction
  - Qualified Service Providers

**Help**

**Provider Type**  
Select a Provider Type from the available list.

**Licensure / Certification, Specialty & Taxonomy:**  
To add Licensure/Certification, Specialty and/or Taxonomy 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.

**Taxonomy**  
Enter as 10 digit/alpha characters.

**Provider Type**  
Physicians

**Licensure and Certification - Section 2**

**Note:** Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered.

**Licensure and Certification List**

License #	Lic/Cert Agency	Cert #	State	Effective Date	Expiration Date
<b>Add License / Certification</b>					

**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**

Specialty	Provider Type	Certification #	State	Board Name	Begin Date	End Date
<b>Add Specialty</b>						

**Taxonomy**

**Add Taxonomy**

Step	Action
3.	<b>Section 2 – <u>Licensure</u> is required.</b>
Step	Action
4.	Click the <b>Add Licensure / Certification</b> button.

**Licensure and Certification - Section 2**

**Note:** Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered.

**Licensure and Certification List**

License #	Lic/Cert Agency	Cert #	State	Effective Date	Expiration Date
<b>Add License / Certification</b>					

**Add License and Certification**

**Save | Reset | Cancel**

**Add all licenses and certificates. For each instance indicate if you are entering a license or a certification.**

**\*Are you adding License or Certification information?**

☐ License ☐ Certification

**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**

Specialty	Provider Type	Certification #	State	Board Name	Begin Date	End Date
<b>Add Specialty</b>						

**Taxonomy**

Step	Action
5.	Click the <b>License or Certification</b> option.

Step	Action
6.	Enter the desired information into the <b>License #</b> field. <b>If the license does not have an assigned number, enter '00000'.</b>
Step	Action
7.	Click the <b>Licensing Agency</b> list.
Step	Action
8.	Click the <b>Appropriate Licensing Agency</b> list item.
Step	Action
9.	Enter the <b>Effective Date</b> .
Step	Action
10.	Enter the <b>Expiration Date</b> .
Step	Action
11.	Click the <b>Save</b> button. <b>Save</b>
Step	Action
12.	<b>If the provider has multiple License/Certifications, repeat steps 4 -11.</b>

Application Tracking Number - 124004  
Instructions  
Identifying Information  
Licensure / Certification  
Provider Identifier Numbers  
Service Location  
Billing  
Group Affiliation  
Electronic Transaction Submission  
Ownership  
Exclusion / Sanction  
Qualified Service Providers

Help  
Provider Type  
Select a Provider Type from the available list.  
Licensure / Certification, Specialty & Taxonomy:  
To add Licensure/Certification, Specialty and/or Taxonomy 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.  
Taxonomy  
Enter as 10 digit/alpha characters.  
Date  
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the calendar icon.

Provider Type  
Physicians

Licensure and Certification - Section 2

System successfully saved the Information.  
Note: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered.

Licensure and Certification List

License #^v	Lic/Cert Agency^v	Cert #^v	State^v	Effective Date^v	Expiration Date^v
UN45339990	State Board of Medical Examiners		North Dakota	12/01/2009	12/31/2014

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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.

Add Specialty

Specialty List

Specialty^v	Provider Type^v	Certification #^v	State^v	Board Name^v	Begin Date^v	End Date^v
-------------	-----------------	-------------------	---------	--------------	--------------	------------

Taxonomy

Add Taxonomy

**Specialty:** Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes: <https://www.bhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

Step	Action
13.	Click the <b>Add Specialty</b> button. <b>Add Specialty</b> <b>*A specialty type is required for all enrollments.</b>

**Specialty & Taxonomy:**  
To add Licensure/Certification, Specialty and/or Taxonomy 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.

**Taxonomy**  
Enter as 10 digit/alpha characters.

**Date**  
Enter as MM/DD/YYYY, MM-DD-YYYY, MDDYYYY 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.

**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**

Specialty^^	Provider Type^^	Certification #^^	State^^	Board Name^^	Begin Date^^	End Date^^
<b>Add Specialty</b>						
*Specialty	*Provider Type					
	Physicians					
*Begin Date	*End Date		*State			
			North Dakota			
*Certification #	*Board Name					
<b>Taxonomy</b>						
Taxonomy^^	Begin Date^^	End Date^^				

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Step	Action
14.	Click the <b>Specialty</b> list.
Step	Action
15.	Select the <b>Appropriate Specialty</b> list item.
Step	Action
16.	Enter the <b>Begin Date</b> .
Step	Action
17.	Enter the <b>End Date</b> . Enter 12/31/9999.
Step	Action
18.	Enter the desired information into the <b>Certification #</b> field. If the certification does not have an assigned number, enter '00000'.
Step	Action
19.	Click the <b>Board Name</b> list.
Step	Action
20.	Select the <b>Appropriate Board name</b> list item.
Step	Action
21.	Click the <b>Save</b> link. <b>Save</b>

**Taxonomy:** Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes:

<https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

The screenshot shows the 'Specialty & Taxonomy' section of the MMIS portal. On the left, there are instructions for adding licensure/certification, specialty, and taxonomy information. The main area displays a 'Specialty List' table with columns for Specialty, Provider Type, Certification #, State, Board Name, Begin Date, and End Date. Below this is a 'Taxonomy' section with an 'Add Taxonomy' button highlighted by a red rectangle. At the bottom, there are buttons for 'Continue', 'Reset', 'Save', and 'Exit Application'.

Specialty	Provider Type	Certification #	State	Board Name	Begin Date	End Date
Internal Medicine	Physicians	CN88988589	North Dakota	AmBd Internal Medicine	12/01/2009	12/31/2014

Step	Action
22.	<p>Click the <b>Add Taxonomy</b> button.</p> <p><b>Add Taxonomy</b></p> <p><b>*A Taxonomy code is required for all providers except Atypical providers (QSP's, Transportation, and Developmental Disabilities).</b></p>

**Specialty & Taxonomy:**  
To add Licensure/Certification, Specialty and/or Taxonomy 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.

**Taxonomy**  
Enter as 10 digit/alpha characters.

**Date**  
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY 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.

**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 Specialty](#)

Specialty^v	Provider Type	Certification #^v	State^v	Board Name^v	Begin Date^v	End Date^v
<a href="#">Internal Medicine</a>	<a href="#">Physicians</a>	CN88988589	North Dakota	AmBd Internal Medicine	12/01/2009	12/31/2014

1 - 1 of 1

**Taxonomy** [Add Taxonomy](#)

Taxonomy^v	Begin Date^v	End Date^v
<b>Add Taxonomy</b> <a href="#">Save</a>   <a href="#">Reset</a>   <a href="#">Cancel</a>		
*Taxonomy (10 digits/alphas)	*Begin Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<a href="#">Continue&gt;&gt;</a> <a href="#">Reset</a> <a href="#">Save</a> <a href="#">Exit Application</a>		

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Step	Action
23.	Enter the desired information into the <b>Taxonomy (10 digits/alphas)</b> field.
Step	Action
24.	Enter the <b>Begin Date</b> .
Step	Action
25.	Enter the <b>End Date</b> . Enter 12/31/9999.
Step	Action
26.	Click the <b>Save</b> link. <a href="#">Save</a>



**Specialty & Taxonomy:**  
To add Licensure/Certification, Specialty and/or Taxonomy 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.

**Taxonomy**  
Enter as 10 digit/alpha characters.

**Date**  
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY 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.

**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 Specialty](#)

Specialty^v	Provider Type	Certification #^	State^v	Board Name^v	Begin Date^	End Date^v
Internal Medicine	Physicians	CN88988589	North Dakota	AmBd Internal Medicine	12/01/2009	12/31/2014

1 - 1 of 1

**Taxonomy**

System successfully saved the Information.


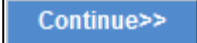
[Add Taxonomy](#)

Taxonomy^v	Begin Date^v	End Date^v
1234567890	12/01/2009	12/31/2014

1 - 1 of 1

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

https://mmis.nd.gov/portals/wps/portal/ut/p/c5/hY5JDoJAEDXPwgmqQCaxZ... Computer Services, Inc. All Rights Reserved.  
Use | Browser Requirements | Accessibility Compliance

Step	Action
27.	Click the <b>Save</b> button. 
Step	Action
28.	Click the <b>Continue&gt;&gt;</b> button. 
Step	Action
29.	The next section will take you through how to complete the Provider Identifier Numbers page. <b>End of Procedure.</b>

# Provider Identifier Numbers

## Procedure

**Provider Identifier Numbers**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers**
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- 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.

**Provider Identifier Number- Section 3**

**National Provider Identification (NPI)**

**Drug Enforcement Agency (DEA) #**

**Add NPI**

**Add DEA #**

**NPI**

**DEA Number**

**Are you or have you been previously enrolled as a Medicaid Provider in another state?**

☐ Yes ☐ No

**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 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 Number	Medicare Program	Begin Date	End Date

Step	Action
1.	<div>Click the <b>Add NPI</b> button.</div> <div><b>Add NPI</b></div> <div><b>*Required for all providers except Atypical (QSP, Transportation, Meals, and Lodging) providers.</b></div>

**Provider Identifier Numbers**

**Required Field**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers**
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- 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.

**Medicare**

**Provider Identifier Number- Section 3**

**National Provider Identification (NPI)**

Add NPI

NPI~

\*NPI

Save | Reset | Cancel

**Drug Enforcement Agency (DEA) #**

Add DEA #

DEA Number~

\*Are you or have you been previously enrolled as a Medicaid Provider in another state?

☐ Yes ☒ No

**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 determining if your Medicare number is your individual number or is affiliated with a group, please contact your Medicare intermediary.

**Medicare Numbers**

Add Medicare

Step	Action
2.	Enter the <b>individual provider's</b> NPI information into the <b>NPI</b> field.
Step	Action
3.	Click the <b>Save</b> link. <b>Save</b>

**Provider Identifier Numbers**

**Required Field**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers**
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- 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.

**Medicare**

**Provider Identifier Number- Section 3**

**National Provider Identification (NPI)**

Add NPI

NPI~

1649281361

1 - 1 of 1

\*Are you or have you been previously enrolled as a Medicaid Provider in another state?

☐ Yes ☒ No

**Drug Enforcement Agency (DEA) #**

Add DEA #

DEA Number~

**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 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 Number~ Medicare Program~ Begin Date~ End Date~

Step	Action
4.	Click the <b>Add DEA #</b> button. <b>Required for individuals with a DEA.</b> <div>Add DEA #</div>

The screenshot shows the 'Provider Identifier Numbers' form in the MMIS system. The form is titled 'Provider Identifier Numbers' and includes sections for NPI, DEA, and Medicare. The 'Add DEA #' button is highlighted with a red box. The 'DEA Number' field is also highlighted with a red box. The form includes a sidebar with 'Application Links' and 'Help' sections.

Step	Action
5.	Enter the <b>individual provider's</b> DEA information into the <b>DEA Number</b> field.
Step	Action
6.	Click the <b>Save</b> button. <div>Save</div>

Provider Identifier Numbers

**\* Required Field**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers**
  - Service Location
  - Billing
  - Group Affiliation
  - Electronic Transaction Submission
  - Ownership
  - Exclusion / Sanction
  - 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.

**Medicare**

**Provider Identifier Number- Section 3**

**National Provider Identification (NPI)**

Add NPI

NPI 1649281361  
1 - 1 of 1

**Drug Enforcement Agency (DEA) #**

Add DEA #

System successfully saved the Information.  
DEA Number DE1234567  
1 - 1 of 1

**\*Are you or have you been previously enrolled as a Medicaid Provider in another state?**

☒ Yes ☐ No

Other Medicaid State

**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 determining if your Medicare number is your individual number or is affiliated with a group, please contact your Medicare intermediary.

**Medicare Numbers**

Add Medicare

Step	Action
7.	Click the <b>Yes or No</b> option.
Step	Action
8.	If YES, select the <b>Other Medicaid State</b> from the list.

**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.

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

**Medicare History**  
Enter the required information for former Medicare Carrier/Intermediaries

**Date**  
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY 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 to the next step. If you choose to **Exit Application**, please save

**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 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 Number^v	Medicare Program^v	Begin Date^v	End Date^v
<b>Add Medicare #</b> <a href="#">Save</a>   <a href="#">Reset</a>   <a href="#">Cancel</a>			
*Medicare Number	*Begin Date	*End Date	
*Please check all that apply:			
<input type="checkbox"/> All <input type="checkbox"/> Medicare Program A <input type="checkbox"/> Medicare Program B <input type="checkbox"/> Medicare Program C <input type="checkbox"/> Medicare Program D			

**Medicare History**

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

Medicare #^v	Carrier/Intermediary Name^v	Medicare Program^v	Begin Date^v	End Date^v
<b>Add History</b>				

Step	Action
9.	Click the <b>Add Medicare</b> button. <b>Add Medicare</b>
Step	Action
10.	Enter the <b>individual provider's Medicare</b> information into the <b>Medicare Number</b> field.
Step	Action
11.	Enter the <b>Begin Date</b> .
Step	Action
12.	Enter the <b>End Date</b> . Enter <b>12/31/9999</b> .
Step	Action
13.	Check all Medicare Programs that apply.
Step	Action
14.	Click the <b>Save</b> button. <b>Save</b>

https://mmis.nd.gov/portals/wps/portal/ut/p/c5/hY5JDoIAEEXp4gmqQIZydBBVzZBTYEd0BkWBainN7 North Dakota MMIS ...

Contact your Medicare Intermediary.

**Medicare Numbers**

Add Medicare

Medicare Number^v	Medicare Program^v	Begin Date^v	End Date^v
123456789	A,B,D	12/01/2012	12/31/2014

1 - 1 of 1

**Medicare History**

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

Add History

Medicare #^v	Carrier/Intermediary Name^v	Medicare Program^v	Begin Date^v	End Date^v
Add History Save   Reset   Cancel				

\*Medicare #

\*Carrier/Intermediary Name

\*Begin Date

\*End Date

\*Please check all that apply:

☐ Medicare Program A ☐ Medicare Program B ☐ Medicare Program C ☐ Medicare Program D

Continue>> Reset Save Exit Application

Help  
NPL DEA Medicare and Medicare History

Step	Action
15.	Click the <b>Add History</b> button. <b>Complete this section if you have been assigned a Medicare number in the past that is no longer in use. This section is for informational use only.</b> <b>Add History</b>
Step	Action
16.	Enter the <b>individual provider's Medicare</b> information into the <b>Medicare #</b> field.
Step	Action
17.	Click the <b>Carrier/Intermediary Name</b> list.
Step	Action
18.	Enter the <b>Begin Date</b> .
Step	Action
19.	Enter the <b>End Date</b> .
Step	Action
20.	<b>Check all Medicare Programs that apply.</b>
Step	Action
21.	Click the <b>Save</b> button. <b>Save</b>
Step	Action
22.	Click the <b>Continue&gt;&gt;</b> button. <b>Continue&gt;&gt;</b>

Step	Action
23.	The next section goes through how to complete the Service Location Billing section. <b>End of Procedure.</b>

## Service Location Billing Procedure

The screenshot displays the 'Service Location Information- Section 4' form in a web browser. A red circle highlights the 'Physical Address (P.O. Box not accepted)' section, which includes fields for 'Building, Suite #, etc.', '\*City', '\*State' (set to North Dakota), '\*Zip', and '\*County', along with a 'Validate Address' button. Below this is the 'Service Location Contact Person' section with fields for 'Last Name', 'First Name', 'MI', 'Phone', 'Ext.', 'Fax', 'Cell', and 'Email'. At the bottom is the 'Service- Section 4' section with radio buttons for 'Gender Served' (Male, Female, Both), checkboxes for 'Age Range Served' (All, 0-5 Years, 6-12 Years, 13-17 Years, 18-21 Years, 22-59 Years, 60+ Years), a list of 'Languages Supported' (Albanian, American Sign Language, Arabic, Bangla, English), and a question about defining the service area by 'Counties Served' or 'Distance From Location'.

Step	Action
1.	Enter the desired information into the <b>Physical Address (P.O. Box not accepted)</b> field.
Step	Action
2.	Enter the desired information into the <b>City</b> field.
Step	Action
3.	Enter the desired information into the <b>Zip</b> field.
Step	Action
4.	Click the <b>County</b> list and select the appropriate County.



Service Location Information- Section 4

\*Physical Address (P.O. Box not accepted)  
100 Main Street  
Building, Suite #, etc

\*City Bismarck \*State North Dakota \*Zip 58501

\*County Burleigh

Validate Address

Alternate Address

Select from the list of valid suggestions then click 'Submit', or click 'Cancel' to return to make additional changes.  
Invalid Service Location Address. Please select one of the Alternative Addresses.

☐ 100 W Main Ave.,Bismarck,ND,58501,3851,Burleigh County

☐ Override verification warning, and accept address as entered.

Submit Cancel

Service Location Contact Person

Last Name First Name MI Phone Ext. Fax Cell Email

Service- Section 4

Step	Action
5.	Click the <b>Validate Address</b> button. <b>Validate Address</b>
Step	Action
6.	Click on the Appropriate address.
Step	Action
7.	Click the <b>Submit</b> button. <b>Submit</b>

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/tut/p/c5/nySIDoIAEEXpvgmqmHG3RLMpIF52hASNAyLagRTt>. The page is titled "Service Location Information - Section 1". It contains several form sections:

- Physical Address (P.O. Box not accepted)**: Includes fields for "100 W Main Ave", "Building, Suite #, etc", "City" (Bismarck), "State" (North Dakota), "Zip" (58501), and "County" (Burleigh). A "Validate Address" button is present.
- Add Service Location Phone Numbers**: A button highlighted with a red circle. Below it is a form with "Phone #" and "Fax #" fields, and "Save", "Reset", and "Cancel" links.
- Service Location Contact Person**: A button. Below it is a form with fields for "Last Name", "First Name", "MI", "Phone", "Ext", "Fax", "Cell", and "Email".
- Service- Section 4**: Includes sections for "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, American Sign Language, Arabic, Bangla; Selected: English), and "Please define your service area by Counties served, or by distance from your location." (Counties Served, Distance From Location).

Step	Action
8.	Click the <b>Add Service Location Phone Numbers</b> button.
Step	Action
9.	Enter the desired information into the <b>Phone #</b> field.
Step	Action
10.	Click the <b>Save</b> link. <b>Save</b>

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/!ut/p/c5/hy5JDoIAEEXPwgmQCaXDbSYK0MAHtC4hCDDG5>. The page title is "North Dakota MMIS". The main content area is titled "Service Location Contact Person" and contains several sections. A red rectangle highlights the "Add Service Location Contact Person" section, which includes the following fields: Last Name, First Name, MI, Phone, Ext., Fax, Cell, Email, and Position. Above this section is a "Validate Address" button. Below the highlighted section is a "Service- Section 4" section with the following options: Gender Served (Male, Female), Age Range Served (All, 0-5 Years, 6-12 Years), Languages Supported (Available: Albanian, Selected: English), and a "Save" button.

Step	Action
11.	Click the <b>Add Service Location Contact Person</b> button. <b>Contact person and email address is required.</b> <div>Add Service Location Contact Person</div>
Step	Action
12.	Enter the desired information into the <b>Last Name</b> field.
Step	Action
13.	Enter the desired information into the <b>First Name</b> field.
Step	Action
14.	Enter the desired information into the <b>Phone</b> field.
Step	Action
15.	Click the <b>Position</b> list and select the Appropriate list item.
Step	Action
16.	Click the <b>Save</b> link. <div>Save</div>

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:  Selected: English

Albanian  
American Sign Language  
Arabic  
Bangla

Other Language:

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

? \*Is this location Wheelchair accessible?  
☐ Yes ☐ No

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

? \*Does this location provide after-hours services?  
☐ Yes ☐ No

? \*Do you wish to be excluded from public provider searches?  
☐ Yes ☐ No

? \*Are you a 340b Provider?  
☐ Yes ☐ No

Hours Of Operation

Interpretive Services Available

Step	Action
17.	Click the <b>Appropriate Gender</b> option.
Step	Action
18.	Click the <b>Appropriate Age Range and Language</b> options.

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:  Selected: English

Albanian  
American Sign Language  
Arabic  
Bangla

Other Language:

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

? \*Is this location Wheelchair accessible?  
☐ Yes ☐ No

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

? \*Does this location provide after-hours services?  
☐ Yes ☐ No

? \*Do you wish to be excluded from public provider searches?  
☐ Yes ☐ No

? \*Are you a 340b Provider?  
☐ Yes ☐ No

Hours Of Operation

Interpretive Services Available

Step	Action
19.	Click the <b>Counties Served or Distance From Location</b> option.
Step	Action
20.	Click the <b>Distance From Location or choose the Counties Served</b> list.
Step	Action
21.	Click <b>Yes or No</b> on questions 1-6. <b>Note: The question pertaining to 340b provider is for pharmacy providers only. Select the ‘No’ radio button.</b>
Step	Action
22.	<b>Hours of Operation, Interpretive Services, and Special Needs</b> sections <b>optional</b> for individual enrollment applications.

The screenshot displays a web application interface for the North Dakota MMIS portal. A red oval highlights three optional sections: 'Hours Of Operation', 'Interpretive Services Available', and 'Special Needs'. The 'Hours Of Operation' section includes a table with columns for 'Day of Week', 'Open', and 'Close', and an 'Add Hours of Operation' button. The 'Interpretive Services Available' section has an 'Add Interpretive Services Available' button and a dropdown menu. The 'Special Needs' section contains a list of checkboxes for various disabilities: Mental Health, Substance Abuse, Development, Behaviorally Disruptive, Other, Deaf/Hearing Impaired, HIV/AIDS, Physical Handicapped, Sexually Aggressive, and Blind/Visually Impaired. Below these sections is a 'Clinical Laboratory Improvement Amendments (CLIA)' section, followed by a 'Mailing Address' section with a question about whether the mailing address is the same as the service location, and a 'Mailing Location Phone Numbers' section with an 'Add Mailing Location Numbers' button.

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/ut/p/c5/hY5IDoIAEEXpvgmqGBuXzRBpFFGgQ0hwQEiw4IQ4f5>. The page is titled 'North Dakota MMIS ...'. It contains several sections: 'Hours Of Operation' with 'Add Hours of Operation', 'Day of Week', 'Open', and 'Close' buttons; 'Interpretive Services Available' with 'Add Interpretive Services Available' and 'Interpretive Services Available' buttons; 'Special Needs' with checkboxes for 'Mental Health Disabilities', 'Substance Abuse Disabilities', 'Development Disabilities', 'Behaviorally Disruptive Disabilities', 'Other Disabilities' (checked), 'Deaf/Hearing Impaired Disabilities', 'HIV/AIDS Disabilities', 'Physical Handicapped Disabilities', 'Sexually Aggressive Disabilities', and 'Blind/Visually Impaired Disabilities'; 'Clinical Laboratory Improvement Amendments (CLIA)' (highlighted with a red box); and 'Mailing Address' with a question '\*Is this mailing address the same as service location?' and 'Yes'/'No' radio buttons. An 'Add Mailing Location Numbers' button is at the bottom right.

Step	Action
23.	<b>CLIA</b> section does not apply to individual enrollment applications. Skip this section.

**Clinical Laboratory Improvement Amendments (CLIA)**

System successfully saved the information

Add CLIA

CLIA #^v	Begin Date^v	End Date^v
35D1055181	12/01/2012	12/31/2012

1 - 1 of 1

**Mailing Address**

\*Is this mailing address the same as service location?

☒ Yes ☐ No

Add Mailing Location Numbers

**Mailing Location Phone Numbers**

Phone	Fax #^v

**Service Location Contact Person(s)**

Add Mailing Location Contact Person

**Mailing Location Contact Person**

Last Name^v	First Name^v	MI^v	Phone^v	Ext.^v	Fax^v	Email^v

**Electronic Funds Transfer (EFT) Payments**

Do you wish to participate in Electronic Funds Transfer Payments?

Step	Action
24.	Click the <b>Yes or No</b> on the Mailing Address option. If <b>No</b> , complete the Mailing Address information.
Step	Action
25.	<b>Contact person and email address is required.</b>

Step	Action
26.	Click the <b>Yes or No</b> option for Electronic Funds Transfer Payments. <b>This should only be completed if the individual will be submitting Medicaid claims as an Independent provider billing under the Social Security Number (SSN). If the individual is a rendering provider only, this section should be left blank. Do not enter the group EFT information on an individual application. Select 'No' if the individual will not be billing independently.</b>
Step	Action
27.	If Yes, Enter the desired information into the <b>Bank Name</b> field.
Step	Action
28.	Enter the desired information into the <b>Bank Address</b> field.
Step	Action
29.	Enter the desired information into the <b>City</b> field.
Step	Action
30.	Click the <b>State</b> list.
Step	Action
31.	Enter the desired information into the <b>Zip</b> field.
Step	Action
32.	Enter the desired information into the <b>Bank Routing Transit Number</b> field.
Step	Action
33.	Enter the desired information into the <b>Bank Account Number</b> field.



Step	Action
34.	Click the <b>Account Type</b> list.
Step	Action
35.	Enter the desired information into the <b>Bank Phone #</b> field.
Step	Action
36.	Enter the desired information into the <b>Account Holder Name</b> field.
Step	Action
37.	Enter the desired information into the <b>Payee Provider's Name</b> field.

The screenshot shows a web browser window with the URL [https://mmis.nd.gov/portals/wps/portal/uk/p/c5/hy7LDolwEEW\\_h5-YQXkua2kwkVbLS2BD5FCj8cGCoPT](https://mmis.nd.gov/portals/wps/portal/uk/p/c5/hy7LDolwEEW_h5-YQXkua2kwkVbLS2BD5FCj8cGCoPT). The page displays a form for account setup. The **Billing Address** section is highlighted with a red rounded rectangle. This section includes a note: "Note: The billing address is equivalent to your Pay To address where your checks will be mailed. \*Is this billing address the same as the service location?" with radio buttons for "Yes" and "No". Below this is a section for "Billing Location Phone Numbers" with an "Add Billing Location Numbers" button and a table with columns for Phone # and Fax #. Another section for "Billing Location Contact Person(s)" has an "Add Billing Location Contact Person" button and a table with columns for Last Name, First Name, Middle Initial, Phone, Ext., Fax, Position, and Email. Below the red box is the "Remittance Advice" section, which includes a note about delivery media (Electronic (835), Web Portal Inbox, or Paper) and a reminder that only one RA option can be chosen.

Step	Action
38.	Click the <b>Yes or No</b> option for Billing Address. If <b>No</b> , Complete the new billing address information.
Step	Action
39.	<b>Contact person and email address is required.</b>

**Billing Location Phone Numbers** [Add Billing Location Numbers](#)

Phone # Fax #

**Billing Location Contact Person(s)** [Add Billing Location Contact Person](#)

Last Name First Name Middle Initial Phone Ext. Fax Position Email

**Remittance Advice**

\*Requested Delivery Media for Remittance Advices(RAs)

☐ Electronic (835) ☐ Web Portal Inbox ☐ Paper

Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed.

**Other Details**

- Print Suspense: Choose one of the following options if you would like to include your suspended claims on your Remittance Advice
- RA Sort Indicator: How would you like your Remittance Advice sorted? If none is chosen, the RA will default to the Members last name
- Bulletin Media : How would you like to receive your bulletins?

Print Suspense RA Sort Ind Bulletin Media

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

**Help**

**Service Location**  
Enter the physical address of your primary

Step	Action
40.	<p>Click the <b>Appropriate RA</b> option. <b>If the individual provider is a rendering provider only, select ‘Web Portal Inbox’.</b> The RA option will be driven by the billing provider/group/entity.</p> <p><b>If the individual is a billing entity under the SSN, then the desired RA should be selected.</b></p> <ul style="list-style-type: none"> <li>Electronic 835 – Receive a HIPAA X12 transaction</li> <li>Web Portal Inbox – Received in the ND MMIS inbox</li> <li>Paper – Mailed to the billing address listed</li> </ul>
Step	Action
41.	<p>Click the <b>Save</b> button.</p> <p><a href="#">Save</a></p>
Step	Action
42.	<p>The next section will take you through how to complete the Group Affiliation page.</p> <p><b>End of Procedure.</b></p>

# Group Affiliation

## Procedure

**Group Affiliation**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation**
  - Electronic Transaction Submission
  - Ownership
  - Exclusion / Sanction
  - Qualified Service Providers

**Group Affiliation- Section 5**

**Instructions:**  
List all active North Dakota Medicaid program groups to which you are linked. Important: when performing a service for a group to which you are linked, the group must bill the service under its North Dakota Medicaid group provider number or payment will be issued to you and you will be responsible for reporting this as income for IRS purposes .

**Add Group**

Name of Group Practice^^	North Dakota Provider Number^^	Effective Date^^	Participating PLC^^

Continue>> Reset Save Exit Application

**Help**

**Group Affiliation**  
To add Group Affiliation information, click the 'Add Group' 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, MM-DD-YYYY or MMDYYMM 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.



Step	Action
1.	<p>If the enrolling individual is affiliated to a group or multiple groups, they must be listed in this section to ensure proper payment. <u>This section is required for all rendering providers.</u></p> <p>*Use the current ND Medicaid group number as the provider number.</p> <p>*Multiple Groups can be added.</p>
Step	Action
2.	<p>Click the <b>Add Group</b> button.</p> <p><b>Add Group</b></p>

**Help**

**Group Affiliation**  
To add Group Affiliation information, click the 'Add Group' 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, MM-DD-YYYY or MMDDYYYY 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.

Step	Action
3.	Enter the desired information into the <b>Name of Group Practice</b> field.
Step	Action
4.	Enter the desired information into the <b>North Dakota Provider Number</b> field. <b>This is the group's current ND Medicaid provider number. This number is seven digits long.</b>
Step	Action
5.	Enter the <b>Effective Date</b> . Enter the effective date of the affiliation.
Step	Action
6.	Click the <b>Save</b> link. 
Step	Action
7.	Click the <b>Save</b> button. 
Step	Action
8.	Click the <b>Continue&gt;&gt;</b> button.

Step	Action
10.	The next section will take you through how to complete the Electronic Transaction Submission page. <b>End of Procedure.</b>

## Electronic Transaction Submission

### Procedure

In this section, you will need to choose 1 of the 3 options to submit electronic transactions.

- **ND MMIS Web Portal** – for those that will be entering Medicaid claims directly into the ND MMIS web portal. **Rendering providers billing under a group should select ‘North Dakota Web Portal’. This is the most common scenario.**
- **Vendor Software** – for those that have their own software that creates a batch file and are sent directly to the State to process. PC ACE, for example, would be considered vendor software. A provider selecting this option would be acting as their own Trading Partner.
- **Billing Agent/Clearinghouse** – for those that use a third party to submit their claims on behalf of the group. The third party is the Trading Partner.

**\*Do not enter the group billing information in this section on an individual application.**

**\*If the individual is the billing entity submitting claims using the SSN and billing through vendor software or a billing agent/clearinghouse, then the appropriate option should be selected.**

Electronic Transaction Submission

Required Field

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission**
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**Help**

**Electronic Transaction Submission**

Select one of the submission methods. Additional information will be required if the selection is Vendor Software or Billing Agent/Clearinghouse.

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

**Electronic Transaction Submission- Section 6**

Providers who choose to submit claims, must be aware that payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted 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 entered through electronic claims submission
- 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:**

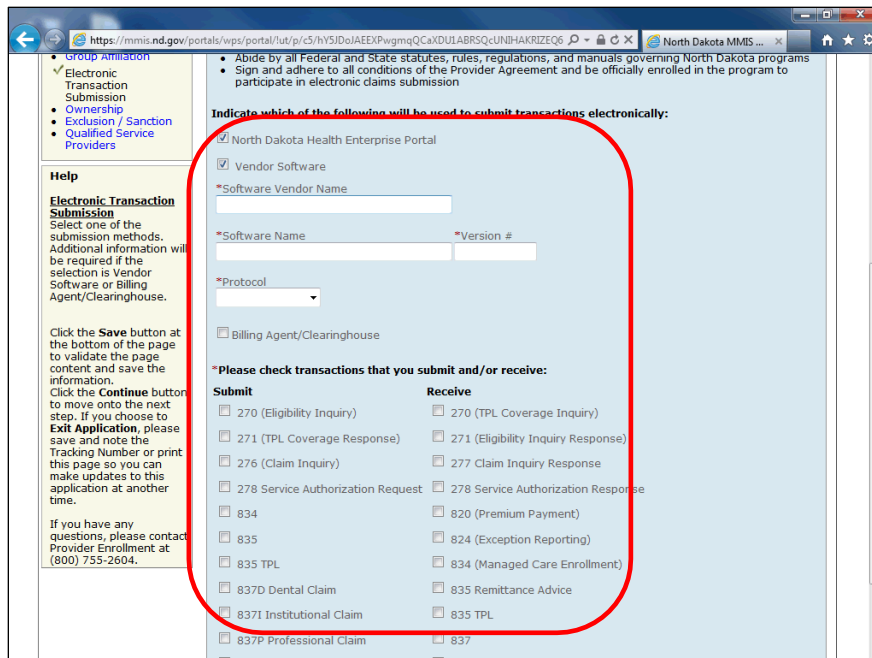
☒ North Dakota Health Enterprise Portal

☐ Vendor Software

☐ Billing Agent/Clearinghouse


**Continue>>** **Reset** **Save** **Exit Application**

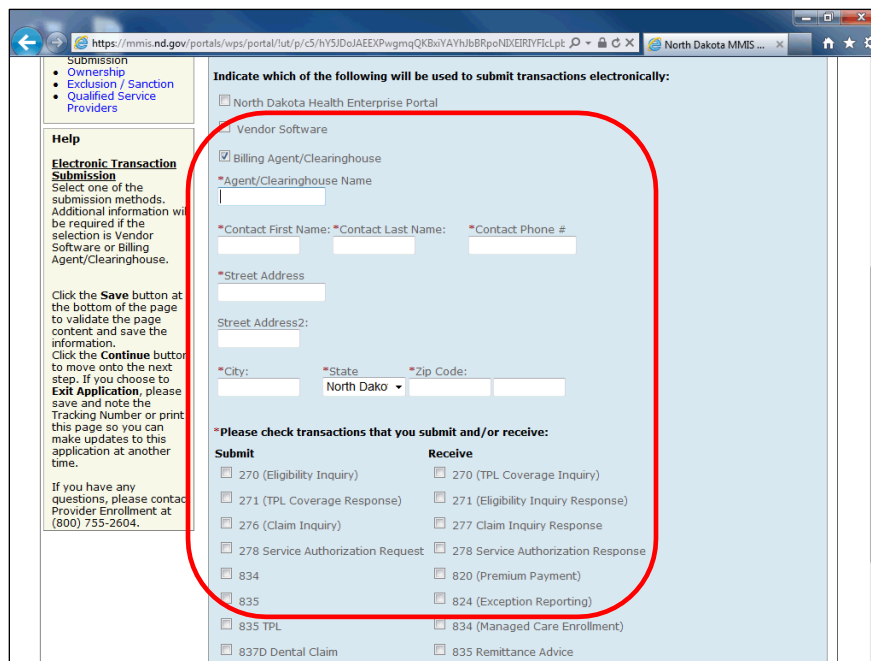
Step	Action
1.	<b>If using ND MMIS Web Portal, claims can be entered directly into the ND MMIS Web Portal.</b>
Step	Action
2.	Click the <b>ND MMIS Web Portal</b> option. <b><u>Select this option if the individual is a rendering provider billing under a group.</u></b>
Step	Action
3.	Click the <b>Save</b> button. 



The screenshot shows the ND MMIS Web Portal interface. On the left, there is a sidebar with a 'Help' section titled 'Electronic Transaction Submission'. The main content area is titled 'Indicate which of the following will be used to submit transactions electronically:'. Under this heading, the 'Vendor Software' option is selected with a checked checkbox. Below this, there are input fields for 'Software Vendor Name', 'Software Name', 'Version #', and a dropdown for 'Protocol'. There is also a checkbox for 'Billing Agent/Clearinghouse'. Further down, there is a section titled '\*Please check transactions that you submit and/or receive:' which contains two columns of checkboxes for various transaction types, including '270 (Eligibility Inquiry)', '271 (TPL Coverage Response)', '276 (Claim Inquiry)', '278 Service Authorization Request', '834', '835', '835 TPL', '837D Dental Claim', '837I Institutional Claim', '837P Professional Claim', '270 (TPL Coverage Inquiry)', '271 (Eligibility Inquiry Response)', '277 Claim Inquiry Response', '278 Service Authorization Response', '820 (Premium Payment)', '824 (Exception Reporting)', '834 (Managed Care Enrollment)', '835 Remittance Advice', '835 TPL', and '837'.

Step	Action
4.	<b>If submission is through a Vendor Software (X12 Transaction), the Provider will be acting as their own Trading Partner.</b>
Step	Action
5.	Click the <b>Vendor Software</b> option.
Step	Action
6.	Enter the desired information into the <b>Software Vendor Name</b> field.

Step	Action
7.	Enter the desired information into the <b>Software Name</b> field.
Step	Action
8.	Enter the desired information into the <b>Version #</b> field.
Step	Action
9.	Click the <b>Protocol</b> list and select the <b>Appropriate</b> list item.
Step	Action
10.	Click the <b>Appropriate Submit and Receive</b> options.
Step	Action
11.	Click the <b>Save</b> button. 



Submission

- Ownership
- Exclusion / Sanction
- Qualified Service Providers

Help

**Electronic Transaction Submission**  
Select one of the submission methods. Additional information will be required if the selection is Vendor Software or Billing Agent/Clearinghouse.

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.

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

☐ North Dakota Health Enterprise Portal

☐ Vendor Software

☒ Billing Agent/Clearinghouse

\*Agent/Clearinghouse Name  
[Text Field]

\*Contact First Name: [Text Field] \*Contact Last Name: [Text Field] \*Contact Phone #: [Text Field]

\*Street Address  
[Text Field]


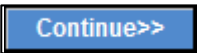
Street Address2:  
[Text Field]

\*City: [Text Field] \*State: North Dakota [Dropdown] \*Zip Code: [Text Field]

\*Please check transactions that you submit and/or receive:

Submit	Receive
<input type="checkbox"/> 270 (Eligibility Inquiry)	<input type="checkbox"/> 270 (TPL Coverage Inquiry)
<input type="checkbox"/> 271 (TPL Coverage Response)	<input type="checkbox"/> 271 (Eligibility Inquiry Response)
<input type="checkbox"/> 276 (Claim Inquiry)	<input type="checkbox"/> 277 Claim Inquiry Response
<input type="checkbox"/> 278 Service Authorization Request	<input type="checkbox"/> 278 Service Authorization Response
<input type="checkbox"/> 834	<input type="checkbox"/> 820 (Premium Payment)
<input type="checkbox"/> 835	<input type="checkbox"/> 824 (Exception Reporting)
<input type="checkbox"/> 835 TPL	<input type="checkbox"/> 834 (Managed Care Enrollment)
<input type="checkbox"/> 837D Dental Claim	<input type="checkbox"/> 835 Remittance Advice

Step	Action
12.	<b>If submission is through a Billing Agent/Clearinghouse, the Agent/Clearinghouse will have to enroll as a trading partner through ND MMIS Web Portal.</b>
Step	Action
13.	Click the <b>Billing Agent/Clearinghouse</b> option.

Step	Action
14.	Enter the desired information into the <b>Agent/Clearinghouse Name</b> field.
Step	Action
15.	Enter the desired information into the <b>Contact First Name:</b> field.
Step	Action
16.	Enter the desired information into the <b>Contact Last Name:</b> field.
Step	Action
17.	Enter the desired information into the <b>Contact Phone #</b> field.
Step	Action
18.	Enter the desired information into the <b>Street Address</b> field.
Step	Action
19.	Enter the desired information into the <b>City:</b> field.
Step	Action
20.	Enter the desired information into the <b>Zip Code:</b> field.
Step	Action
21.	Click the <b>Appropriate Submit and Receive</b> options.
Step	Action
22.	Click the <b>Save</b> button. 
Step	Action
23.	Click the <b>Continue&gt;&gt;</b> button. 
Step	Action
24.	The next section will take you through how to complete the Ownership page. <b>End of Procedure.</b>



# Ownership Procedure

**Ownership**

**Ownership- Section 7**

\*1. Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services?

☐ Yes ☐ No

\*2. Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services?

☐ Yes ☐ No

\*3. Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates some of its management functions or responsibilities of providing medical care to its patients.)

☐ Yes ☐ No

\*4. Do any of the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice?

☐ Yes ☐ No

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership**
- Exclusion / Sanction
- 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 Relative

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

Step	Action
1.	Click the <b>Yes or No</b> option for questions 1 – 4. If <b>Yes</b> , complete the additional fields. If <b>No</b> , continue to next section.

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/tut/p/c5/hy5JDoIAEEXpvgmqQCaXSHcwkWSUm8DiANDZFgQ>. The page title is "North Dakota MMIS ...". The main content area is titled "Add Ownership" and contains a form with the following fields and options:

- Business Name** (dropdown)
- Current ND Provider #** (dropdown)
- Medicare #** (dropdown)
- Effective Date** (dropdown)
- End Date** (dropdown)
- State** (dropdown)
- Add Ownership** (button)
- Add Ownership Information** (section header)
- Save | Reset | Cancel** (links)
- \*Organization's Legal Business Name** (text input)
- \*Effective Date** (text input)
- \*End Date** (text input)
- \*Address** (text input)
- \*City** (text input)
- \*State** (dropdown menu, currently showing "North Dakota")
- \*Zip** (text input)
- \*EIN Number** (text input)
- \*Please enter your NPI and/or Medicaid numbers. Indicate Medicare or Medicaid by checking a box below.**
- \*NPI #** (text input)
- ☐ Medicare
- ☐ Medicaid
- \*1. Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services?**
- ☒ Yes ☐ No
- \*2. Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services?**
- ☐ Yes ☐ No
- \*3. Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates some of its management functions or responsibilities of providing medical care to its patients.)**
- ☐ Yes ☐ No

Step	Action
2.	If Yes, Enter the information into the <b>Organization's Legal Business Name</b> field.
Step	Action
3.	Enter the <b>Effective Date and End Date</b> .
Step	Action
4.	Enter the desired information into the <b>Address</b> field.
Step	Action
5.	Enter the desired information into the <b>City</b> field.
Step	Action
6.	Enter the desired information into the <b>Zip</b> field.
Step	Action
7.	Enter the desired information into the <b>EIN Number</b> field.
Step	Action
8.	Enter the desired information into the <b>NPI #</b> field.
Step	Action
9.	Click the <b>Appropriate Medicare or Medicaid</b> option.
Step	Action
10.	Enter the desired information into the <b>Current ND Provider #</b> field.
Step	Action
11.	Click the <b>Save</b> link.

Number -124004

- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership**
- Exclusion / Sanction
- Qualified Service Providers

\*1. Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services?

☒ Yes ☐ No

System successfully saved the Information.

Add Ownership

Business Name^v	Current ND Provider #^v	Medicare #^v	Effective Date^v	End Date^v	State^v
Organization 1	1450419		12/01/2012	12/31/2012	North Dakota

1 - 1 of 1

\*2. Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services?

☐ Yes ☐ No

\*3. Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates some of its management functions or responsibilities of providing medical care to its patients.)


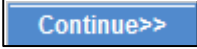
☐ Yes ☐ No

\*4. Do any of the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice?

☐ Yes ☐ No

Continue>> Reset Save Exit Application

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

Step	Action
12.	Repeat the steps for questions 2 – 4. Answering Yes to these questions will require additional information to be completed.
Step	Action
13.	Click the <b>Save</b> button. 
Step	Action
14.	Click the <b>Continue&gt;&gt;</b> button. 
Step	Action
15.	The next section will take you through how to complete the Exclusion / Sanction page. <b>End of Procedure.</b>

# Exclusion/Sanction Procedure

**Exclusion / Sanction**

**Required Field**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction**
- Qualified Service Providers

**Help**

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

**Name and Federal Program**  
To add Name and/or 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.

**Exclusion/Sanction- Section 7**

\*1. Have you or any member of your immediate family ever been convicted, assessed or excluded from the Medicare, Medicaid, State Health Insurance Program or any other federal or state program due to fraud, obstruction of an investigation or a controlled substance violation?  
☐ Yes ☐ No

\*2. Do you, under any name or business identity, have any outstanding overpayments with any state or federal program?  
☐ Yes ☐ No

\*3. Have you 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).

\*4. Administrative Sanction(s)?  
☐ Yes ☐ No

\*5. Professional Board Disciplinary Action(s)?  
☐ Yes ☐ No

\*6. Program Exclusions?  
☐ Yes ☐ No

Step	Action
1.	If <b><u>YES</u></b> is answered for any question in this section, you will be required to provide additional information.
Step	Action
2.	Click the <b>Yes or No</b> option for questions 1 - 15.

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction**
- Qualified Service Providers

**Required Field**

**Exclusion/Sanction- Section 7**

\*1. Have you or any member of your immediate family ever been convicted, assessed or excluded from the Medicare, Medicaid, State Health Insurance Program or any other federal or state program due to fraud, obstruction of an investigation or a controlled substance violation?

☒ Yes ☐ No

**Add Name**

Last Name  First Name  MI  Suffix  Relationship

**Add Family/Household Member Information**

Last Name  First Name  MI  Suffix  Relationship

**Help**

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

**Name and Federal Program**  
To add Name and/or 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 of Occurrence**  
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY

\*2. Do you, under any name or business identity, have any outstanding overpayments with any state or federal program?

☐ Yes ☐ No

\*3. Have you 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).

\*4. Administrative Sanction(s)?

☐ Yes ☐ No

**Save** **Reset** **Cancel**


**Continue>>**



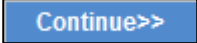
Step	Action
3.	If <b>Yes</b> , complete the additional information.
Step	Action
4.	If <b>No</b> is selected, no further information is needed.
Step	Action
5.	Click the <b>Save</b> button. <b>Save</b>
Step	Action
6.	Click the <b>Continue&gt;&gt;</b> button. <b>Continue&gt;&gt;</b>
Step	Action
7.	The next section will take you through how to complete the Qualified Service Providers page. <b>End of Procedure.</b>

## Qualified Service Providers

### Procedure

The screenshot shows the North Dakota MMIS portal. On the left is a navigation menu with options like 'Identifying Information', 'Licensure / Certification', 'Provider Identifier Numbers', 'Service Location', 'Billing', 'Group Affiliation', 'Electronic Transaction Submission', 'Ownership', 'Exclusion / Sanction', and 'Qualified Service Providers'. The main content area is titled 'Non-Medical Provider (meals, lodging, transportation)'. It instructs users to 'List your Medicaid eligible recipients. You must list at least one recipient to enroll as a provider.' A blue button labeled 'Add Medicaid Eligible Recipients' is highlighted with a red box. Below this is a table with columns for 'Medicaid ID', 'Last Name', 'First Name', 'MI', and 'Suffix'. Below the table is a form titled 'Add Medicaid Eligible Recipients' with fields for '\*Medicaid ID', '\*Last Name', '\*First Name', 'MI', and 'Suffix'. There are also checkboxes for '\*Does the recipient reside in the same household?' (Yes/No) and '\*Is the recipient a Foster Child or Adult?' (Yes/No). A dropdown menu for 'What is your relationship to the person you are providing services?' is also present. At the bottom of the form are buttons for 'Continue>>', 'Reset', 'Save', and 'Exit Application'.

Step	Action
1.	<p><b>If not enrolling as a Non-Medical Provider (QSP, Transportation, Meals, and Lodging providers), this section can be skipped.</b></p> <p>If you did not select Qualified Service Provider as a Provider Type or one of the following Specialties:</p> <ul style="list-style-type: none"> <li>1) Lodging</li> <li>2) Provide Meals</li> <li>3) Private Vehicle</li> <li>4) QSP</li> </ul> <p>This Section can be skipped.</p>
Step	Action
2.	<p>Click the <b>Add Medicaid Eligible Recipients</b> button.</p> 
Step	Action
3.	Enter the desired information into the <b>Medicaid ID</b> field.
Step	Action
4.	Enter the desired information into the <b>Last Name</b> field.

Step	Action
5.	Enter the desired information into the <b>First Name</b> field.
Step	Action
6.	Click the <b>Yes or No</b> option.
Step	Action
7.	Click the <b>Yes or No</b> option.
Step	Action
8.	Click the <b>What is your relationship to the person you are providing service</b> list.
Step	Action
9.	Click the <b>Appropriate</b> list item.
Step	Action
10.	Click the <b>Save</b> button. 
Step	Action
11.	Click the <b>Save</b> button. 
Step	Action
12.	Click the <b>Continue&gt;&gt;</b> button. 
Step	Action
13.	The next section will take you through how to complete the Submit Application page. <b>End of Procedure.</b>

## Submit Application Procedure

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**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.

Please enter a User ID of your choice and the following information for the Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords. 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:   
 Prefix:  \*Last Name:  \*First Name:  MI:  Suffix:   
 \*Phone #:  Ext:  Email Address:

**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.

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

Step	Action
1.	<p><b>Read each of the Provider Agreements</b> that pertains to this enrollment.</p> <ul style="list-style-type: none"> <li><b>Medicaid Program Provider Agreement</b> is required for <u>all</u> providers.</li> <li><b>PCCM Agreement</b> is no longer required. The PCCM Program ended effective 12/31/2023.</li> </ul>



**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**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.

Please enter a User ID of your choice and the following information for the Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords. Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advice.

☒ Yes ☐ No

\*Organization Name  \*Organization Description  \*User ID


Prefix  \*Last Name  \*First Name  MI  Suffix

\*Phone #  Ext  Email Address

**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.

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

Step	Action
2.	<b>Registering for Web Access is <u>not recommended for individual rendering providers billing under a group.</u></b> Individual providers billing independently may choose to register for web access.
Step	Action
3.	Enter the desired information into the <b>Organization Name</b> field.
Step	Action
4.	Enter the desired information into the <b>Organization Description</b> field.
Step	Action
5.	Enter the desired information into the <b>User ID</b> field.
Step	Action
6.	Enter the desired information into the <b>Last Name</b> field.
Step	Action
7.	Enter the desired information into the <b>First Name</b> field.
Step	Action
8.	Enter the desired information into the <b>Phone #</b> field.
Step	Action
9.	Click the <b>Save</b> button.
	

**Submit Application Step 1**

**\* Required Field**  
The submitted User ID already exists. Please enter another User ID, or select one of the following suggestions: TOMSMITH, TOMSMITH

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**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

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☒ Yes ☐ No

\*Organization Name: Smith Clinic

\*Organization Description: Clinic

\*User ID: [Redacted]

Prefix: [Dropdown]

\*Last Name: SMITH

\*First Name: TOM

MI: [Dropdown]

\*Phone #: 701-555-5555

Ext: [Text]

Email Address: [Text]

Suffix: [Dropdown]

Step	Action
10.	If the User ID already exists, you will be prompted to enter a different User ID.

**Submit Application Step 1**

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
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Medicaid and Basic Care Assistance Programs Provider Agreement  
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**Register for Web Access**

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☒ Yes ☐ No

\*Organization Name: Smith Clinic

\*Organization Description: Clinic

\*User ID: TOMSMITH

Prefix: [Dropdown]

\*Last Name: SMITH

\*First Name: TOM

MI: [Dropdown]

\*Phone #: 701-555-5555

Ext: [Text]

Email Address: [Text]

Suffix: [Dropdown]

**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.

If you have any questions, please contact Provider Enrollment at (800) 785-2604

Step	Action
11.	Click the <b>Validate Application</b> button. This will check the application for errors. <div>Validate Application</div>

Provider Enrollment - Submit Application Step 2

**Application Links**

- Application Tracking Number -124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location
- Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership
- Exclusion / Sanction
- Qualified Service Providers

**Add Another Service Location**

If you render services at any locations other than the service address entered, click the 'Add Another Service Location' button to enter an additional location and the location-specific information. You may use this button to enter all locations where you render services.

**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.

Add Another Type Add Another Service Location Edit Service Location

Edit Application Save Confirm Submit

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

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Step	Action
12.	Click the required <b>Electronic Signature</b> options.
Step	Action
13.	Enter the <b>Requested Claim Submission Effective Date</b> .
Step	Action
14.	Click the <b>Save</b> button. <div>Save</div>

Provider Enrollment - Submit Application Step 2

\* Required Field

The Provider Enrollment Details have been saved successfully. Please note your Application Tracking number 124004 for future access to the Enrollment Application.

**Application Links**

- Application Tracking Number - 124004
- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Numbers
- Service Location Billing
- Group Affiliation
- Electronic Transaction Submission
- Ownership / Exclusion / Sanction
- Qualified Service Providers

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☒ \*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  
12/01/2012

**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.

[Add Another Type](#) [Add Another Service Location](#) [Edit Service Location](#) [Edit Application](#) [Save](#) [Confirm Submit](#)

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

Step	Action
15.	<b><u>Review the application for accuracy and completeness before submitting the application.</u></b>
Step	Action
16.	<b>Add Another Type and Add Another Service Location should <u>never</u> be used on an individual application.</b> If the individual has <b>more than one provider type</b> , then a separate application is required. If the individual practices at <b>multiple locations</b> , then use the group affiliations page to associate all locations.
Step	Action
17.	<b>If you click the <a href="#">Confirm Submit</a> option, you will not be able to make any further edits to the application.</b>
Step	Action
18.	Click the <b><a href="#">Confirm Submit</a></b> button if you have no edits or updates to make to the application. <a href="#">Confirm Submit</a>

**Provider Enrollment - Submit Complete** Print | Help

**\* Required Field**

Thank you for submitting your application on-line. In order to fully process your application the required documents listed below must be mailed into DHS. Once all documents have been received and your application reviewed you will be notified via mail with the application decision.

You may check the status of your application at any time, through the Application Status function located on the main Enrollment home page or by contacting Provider Enrollment Services at the number listed below, and providing your Application Tracking Number.

**Application Tracking Number**

**Application Tracking Number :124004**  
**TradingPartner Application Tracking Number:124005**

Please make a record of this Application Tracking Number. Use this number when inquiring about the status of the application.

**Print and Review**

The Print Application button may be used to print a copy of the application. This copy is for your records only and should not be sent to DHS. The application will remain available to you on the portal for 30 days after submittal.

Additional documents may be required to be sent in as attachments to your application depending on your provider type. Print the Document Requirements Checklist to identify the supplemental information by provider type that is needed to finalize your application. Mail all additional enrollment documentation to:

**Note:** Include the application tracking number indicated above on all documents that are mailed to DHS in reference to your application.

**North Dakota Department of Human Services**  
**Provider Enrollment**  
 600 E Boulevard Avenue Dept 325  
 Bismarck ND 58505-0250

**Print Required Documents**

1. [Document Requirements Checklist](#)

Once the required document has been printed, click the Exit Application button to return to the ND Provider Enrollment Homepage

Print Application Exit Application

If you have any questions, please call DHS at (800) 755-2604.

[https://mmis.nd.gov/portals/wps/portal/ut/p/c5/hY7LDslwEEV\\_uS-Y4V2XSCsm2iqCCN0QImg0CiwBx06](https://mmis.nd.gov/portals/wps/portal/ut/p/c5/hY7LDslwEEV_uS-Y4V2XSCsm2iqCCN0QImg0CiwBx06)

Step	Action
19.	Click <b>Document Requirements Checklist</b> to determine what Documents need to be sent to the Department of Human Services. <b>**The above screen needs to be printed and mailed with the required documents to ensure there is a reference to the Application Tracking Number (ATN).</b>
Step	Action
20.	Click the <b>Print Application</b> button if you would like to keep a copy for your <b>own records</b> . <b><u>Do not</u> submit a printed application with your required documents.</b> <div><b>Print Application</b></div>

North Dakota Department of Human Services  
Individual Provider Enrollment Application

Submitted on: December 11, 2012  
Application Tracking Number: 124004  
Trading Partner Application Tracking Number: 124005

**Identifying Information – Section 1**

Last Name: Smith First Name: Tim MI:  
Suffix: Title: Date of Birth: 12/15/1960  
Gender: Male Can information about date of birth and gender be available to clients? Yes  
SSN: 505555555

**Current/Previous ND Provider #**  
Current and/or previous ND Provider number: 000012345

**Previous Names**  
Have you used any previous names in the past five years? No  
Last Name: First Name:

**Licensure and Certification – Section 2**  
Provider Type: Physician

Step	Action
21.	Print a copy of the application for your own records. <b><u>Do not</u></b> submit a printed copy with the required documents.

\* Required Field

Thank you for submitting your application on-line. In order to fully process your application the required documents listed below must be mailed into DHS. Once all documents have been received and your application reviewed you will be notified via mail with the application decision.

You may check the status of your application at any time, through the Application Status function located on the main Enrollment home page or by contacting Provider Enrollment Services at the number listed below, and providing your Application Tracking Number.

**Application Tracking Number**

Application Tracking Number: 124004  
Trading Partner Application Tracking Number: 124005

Please make a record of this Application Tracking Number. Use this number when inquiring about the status of the application.

**Print and Review**

The Print Application button may be used to print a copy of the application. This copy is for your records only and should not be sent to DHS. The application will remain available to you on the portal for 30 days after submittal.

Additional documents may be required to be sent in as attachments to your application depending on your provider type. Print the Document Requirements Checklist to identify the supplemental information by provider type that is needed to finalize your application. Mail all additional enrollment documentation to:

**Note:** Include the application tracking number indicated above on all documents that are mailed to DHS in reference to your application.

North Dakota Department of Human Services  
Provider Enrollment  
600 E Boulevard Avenue Dept 325  
Bismarck ND 58505-0250

**Print Required Documents**


1. Document Requirements Checklist

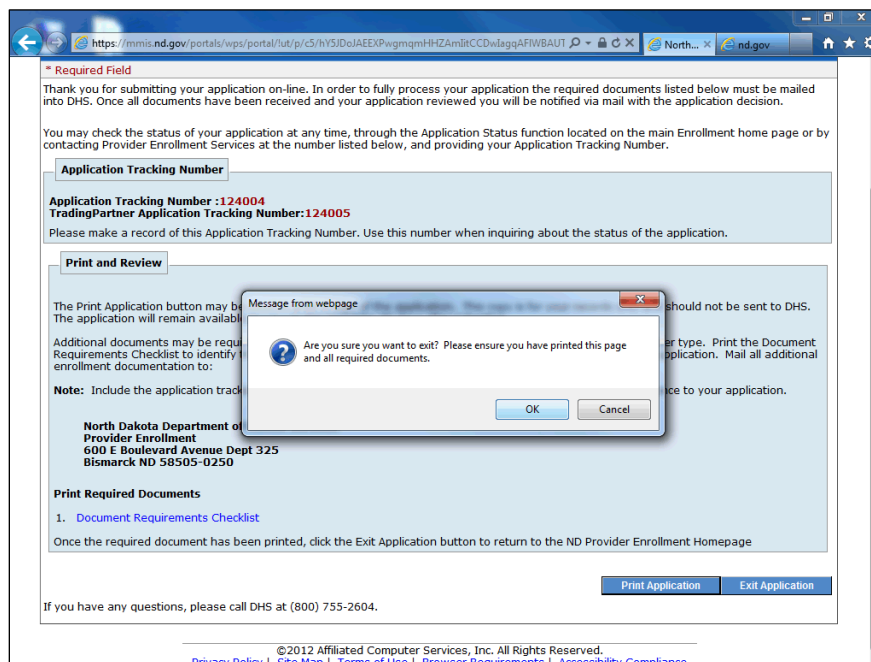
Once the required document has been printed, click the Exit Application button to return to the ND Provider Enrollment Homepage

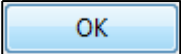
If you have any questions, please call DHS at (800) 755-2604.

Print Application Exit Application

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Step	Action
22.	Click the <b>Exit Application</b> button. 



Step	Action
23.	Click the <b>OK</b> button. 
Step	Action
24.	<b>End of Procedure.</b>