NORTH Dakota Be Legendary.

Health & Human Services

NEMT 034-387
Individual Application Requirements

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

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

Section 1: Provider Information

Application Tracking # (New Applications only):	
Current Medicaid ID # (for Revalidation and Reactivation only):	
Transporter (Provider) Name:	
Service Location:	
Billing Address:	
Mailing Address:	
Facility Phone:	
Contact person / Title:	
Contact phone number:	
Contact email:	
Provider phone number:	
Provider email:	

Provider Type 034-Transportation Services
Specialty 387-Private Vehicle
Taxonomy 347C00000X

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

_____

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

_____

NORTH Dakota Be Legendary.

Health & Human Services

NEMT 034-387
Individual Application Requirements

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

Section 2: Required Documents

1.NEMT Individual Application Requirements

2.SNF 620 – Non-Emergent Medical Transportation

2. Driver's License Issued: _____ Expires: _____

3. Foster License – only for foster parents applying to transport foster children

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

5. SFN 615 - Medicaid Program Provider Agreement
   **Must be signed and dated by the Individual Provider who is applying*

I, the undersigned commercial business owner or independent driver, affirm that the vehicle used to provide transportation is in good operating order, including the brakes, lights and tires. I attest that I have the necessary vehicle insurance that covers transporting passengers for payment. I attest that I have a valid government issued driver's license and I understand that I am required to maintain a copy of the valid driver's license for every driver in their personnel file. I understand I am required to maintain current vehicle registration. I understand that failure to maintain adequate registration, valid insurance coverage, and a valid driver's license may result in termination of Medicaid enrollment.

_____ _____

Signature Date

NORTH Dakota Be Legendary.

Health & Human Services

NEMT 034-387
Individual Application Requirements

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

For questions concerning Provider Enrollment, please contact (877) 328-7098 (toll- free) or (701) 328-7098. Live support 8 am - 5 pm CST, Monday – Friday.