NORTH Dakota Be Legendary.

Health & Human Services

Targeted Case Management Group

Group Application Requirements

☐Child Welfare ☐Long Term Care ☐Behavioral Health ☐High Risk Pregnant Women & Infants

Type of Application: **Date Submitted:** _____

☐New Application

☐Revalidation

☐Reactivation

Section 1: Group Information

Application Tracking # (New application only):	
Current Medicaid ID Number (only used for Revalidation and Reactivation):	
Legal Business Name:	
Organization NPI#:	
Service Address:	
Billing Address:	
Mailing Address:	
Facility Phone Number:	
Contact Person / Title (as listed in MMIS):	
Contact Phone Number:	
Contact Email:	

1. Are you enrolling any other service locations in addition to the location listed in MMIS?
   ****All service locations must be within the United States.*

   ☐Yes ☐No

*If Yes – list addition service locations on the next page (must have the same Provider Type, NPI, EIN, and billing address.)

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Address	City	State	Zip Code

2. Current practicing providers affiliated with this group – SFN 1330
   ****Groups can enroll without completing the SFN 1330 but will not be able to bill until a provider is affiliated.*

Provider Type Either 025-Agencies or 047-Indian Health Services/683 Tribal

Specialty 035-Case Management

Taxonomy 251B00000X

☐ 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: _____.

**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 roles must be sent with the application packet. If you do not submit this information, a date beyond ninety (90) days of receipt of a completed application will not be approved.*

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Section 2: Required Documents:

1. Group Application Requirements
2. CP 575 or 147C **(*Not required if submitting a FEDERAL tax-exempt letter issued by the IRS)**
    a. The IRS form CP 575 is an Internal Revenue Service (IRS) generated letter providers receive from the IRS granting their Employer Identification Number (EIN). The 147C is a replacement letter from the IRS verifying your Legal Business Name and Tax ID. This Letter can be used in place of a CP 575. If unable to locate either of these letters, visit Lost or Misplaced Your EIN? | Internal Revenue Service (irs.gov) for direction.
3. IRS Tax Exempt Letter-501(C3) **(*If Exempt from FEDERAL Taxes)**
A State issued letter cannot be substituted. The letter must be issued by the IRS.
    a. For More information, refer to: Governmental Information Letter | Internal Revenue Service (irs.gov)
4. Group Attestation for each TCM Service you are enrolling to provide.
Child Welfare
High Risk Pregnant Women & Infants
Long Term Care
Behavioral Health
5. SFN 661 – Electronic Fund Transfer (EFT)
    a. 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.
6. SFN 509 – Out of State/Out of Network Enrollment Clarification
***Only required if services are more than 50 miles outside of the ND border and located within the United States**
    a. For more information on Out of State services, refer to: out-of-state-services.pdf (nd.gov)

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7. SFN 1168 – Ownership/Controlling Interest and Conviction Information
    a. List of Managing Employees attached to Section IV (Page 2) with dates of birth and SSNs.
    b. List of Board Members attached to Section IV (Page 2) with dates of birth and SSNs.
8. SFN 615 – Medicaid Program Provider Agreement
    ** Must be signed and dated by a Managing Employee.*

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.