North Dakota Medicaid
Group Provider Application Checklists

You must fill out the checklist for your group entirely and attach the documents indicated on the checklist along with signed signature pages for the packet to be considered complete.

The department does not retain incomplete documents. If this packet is incomplete when it is received, the entire packet will be deleted, and you will receive an email notification at the contact email address entered on the checklist.

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North Dakota Department of Human Services Group Provider Application Checklists

Contents

Group Application Checklists

Other Service Providers (017)

Lodging (017 – 339) 4

Meals (017 – 393) 6

Lodging and Meals (017 – 339 & 393) 8

County Social Service Offices (017 – 468) 10

Agencies (025)

Community Behavioral Health (025 – 357) 12

Targeted Case Management (025 – 035) 14

Home Health Agency (025 – 082) 20

Hospice (025 – 454) 22

Local Education Agency (LEA) (025 – 397) .IEP 24

Local Education Agency (LEA) (025 – 397) NON-IEP 26

Private Duty Nursing (025 – 499) 28

Clinic (Ambulatory Health Care Facility) (026)

General Clinic Checklist (Not for Adolescent & Children Mental Health, Ambulatory Surgical Centers, Dental, FQHC, Physical Therapy, Rehab, or RHC) 30

Applied Behavior Analysis (ABA) (026 – 026) 32

Ambulatory Surgical Center (ASC) Institutional Billing (026 – 089) 34

Ambulatory Surgical Center (ASC) Professional Billing (026 – 503 or 504) 36

Dental (026 – 437 or 503) 38

Federally Qualified Health Center (FQHC) (026 – 361) 40

Federally Qualified Health Center Optometrist, Chiropractor, and/or Podiatrist Billing Group (026 – 503 or 504) 42

Medication Assisted Treatment (MAT) (026 –509) 44

Mental Health (Rehab) (026 – 360) 47

Physical Therapy (026 – 110) 50

Rehabilitation, Substance Use Disorder (026 – 364) 52

Rural Health Clinic (RHC) (026 – 268) 55

Hospital Units (027)

Hospital Unit - Rehabilitation, Substance Use Disorder Unit (027 – 623) 57

Hospital Unit - Swingbed (027 – 196) 59

Hospitals (028)

Hospital Institutional Billing (028) ... 63

Hospital Professional Billing (026 – 503 or 504) ... 66

Laboratory (029) ... 68

Skilled Nursing Facility (031 – 269) ... 70

Residential Treatment Facility (032)

Psychiatric Residential Treatment Facility (032 – 258) ... 72

QRTP (032-264) ... 74

QRTP OLP Billing Group ... 76

Sole Proprietors

Sole Proprietor ... 78

Sole Proprietor – Autism Waiver ... 80

Suppliers (033)

Durable Medical Equipment (DME) ... 82

Pharmacy ... 85

Hearing Aid Specialists (033 – 383) ... 87

Transportation Services (034)

Ambulance ... 89

Developmental Disabilities (039)

Autism Waiver ... 91

Sole Proprietor – Autism Waiver ... 80

Basic Care (043) ... 93

Indian Health Services (IHS)/638 Tribal (047) ... 95

Group Application FAQs ... 102

Group Application Checklist
Lodging (017 - 339)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI # (Not Required)	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

   5a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

6. Is your establishment held out to the public as a place where sleeping accommodations are furnished for pay to transient guests? ☐ YES ☐ NO

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
3. List of Service Locations (Required if you answered Yes to question 1 above)			
4. SFN 620 (12-2021)	Provide the date business was formed (aproximate date is accepted):	SFN 620 (12-2021)	
5. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	
6. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		What is the CP575/147C?	

Section 3: Required Documents Continued

7. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
8. License - Issued by the ND Dept of Health for ND providers) *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* **License #** **Issued:** **Expires:**		
9. SFN 661 (12-2022) **Printed Name of Signing Managing Employee:**	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check **Must match the Information provided on the SFN 661**		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) **Printed Name of Signing Managing Employee:**	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	017-Other Service Providers
SPECIALTY	339-Lodging
TAXONOMY	N/A

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Meals (017 - 393)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI # (Not Required)	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

   5a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
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2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. SFN 620 (12-2021) — Provide the date business was formed (aproximate date is accepted):	SFN 620 (12-2021)	
5. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
6. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
7. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	

Section 3: Required Documents Continued

8. SFN 661 (12-2022) **Printed Name of Signing Managing Employee:**	SFN 661 (12-2022)	
8a. Bank Letter/Voided Check **Must match the Information provided on the SFN 661**		

9. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
9a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
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Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	017-Other Service Providers
SPECIALTY	393-Provide Meals
TAXONOMY	N/A

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Revision **8/22/2023**

Group Application Checklist
Lodging & Meals (017 - 339 & 393)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI # (Not Required)	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

5a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

6. Is your establishment held out to the public as a place where sleeping accommodations are furnished for pay to transient guests? ☐ YES ☐ NO

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
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5. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	
6. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		What is the CP575/147C?	

Section 3: Required Documents Continued

7. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
8. License - Issued by the ND Dept of Health for ND providers) ***(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)*** **License #** | **Issued:** | **Expires:**		
9. SFN 661 (12-2022) | **Printed Name of Signing Managing Employee:**	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — **Must match the Information provided on the SFN 661**		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
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11. SFN 615 (6-2023) | **Printed Name of Signing Managing Employee:**	SFN 615 (6-2023)	

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Section 4: Enrollment Effective Date

PROVIDER TYPE	017-Other Service Providers	
SPECIALTY	339-Lodging	393-Provide Meals
TAXONOMY	N/A	

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Revision 8/22/2023

Group Application Checklist
County Social Service Offices (017 - 468)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Field	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

2. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

3. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

4. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

4a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 1 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	

Section 3: Required Documents Continued

6. NPI prinout from the NPPES Website	NPPES Website	
7. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
7a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
8. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
8a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
8b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
9. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	017-Other Service Providers
SPECIALTY	468-County Social Service Office
TAXONOMY	171M00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Community Behavioral Health (025 - 357)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   7a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Agency License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	025-Agencies
SPECIALTY	357-Community/Behavioral Health
TAXONOMY	251S00000X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

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☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Targeted Case Management Group (025 - 035)

Type of TCM Services provided (Check all you are enrolling to provide):

☐ Child Welfare ☐ Long Term Care ☐ SMI/SED
☐ High Risk Pregnant Women & Infants

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

2. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO

If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?

If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	**Helpful Links**	**Submitted**
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 2 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Group Attestation for each TCM Service you are enrolling to provide. Attestation submitted must match the TCM services checked at the top of this checklist. If enrolling to provide more than one type of service, please submit the attestation for each service.	Child Welfare; Long Term Care; High Risk Pregnant Women & Infants; SMI/SED	
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	Either 025-Agencies or 047-Indian Health Services/638 Tribal
SPECIALTY	035-Case Management
TAXONOMY	251B00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist

Home Health Agency (HHA) (025 - 082)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Field	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**

Please Provide your Medicare ID:

Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES

State Abbv: **Please Provide your Other State Medicaid ID:**

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO

If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

7. What is the name and Medicaid ID, Application Tracking Number, or NPI of the Director or Referring Doctor who will be on your claims as the Attending Practitioner? ***(Institutional claims require an attending be enrolled and entered on claims for processing. The "attending" can be either a medical director or attending/referring doctor. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.)***

Name: **Medicaid ID/ATN/NPI:**

GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES
CHILD WELFARE

________________________ ____________________
Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group provider has met all the following requirements:

(CHECK ALL THAT APPLY):

1. ☐ Has in place a training process that will ensure that staff have adequate knowledge relating to children involved in unsafe, crisis, and/or unstable situations.
2. ☐ Has the ability to be available 24 hours, 7 days a week to eligible clients who are in need of emergency case management services.
3. ____ All Supervisors of case management staff have a minimum of a bachelor's degree in social work, psychology, sociology, counseling, human development, elementary education, early childhood education, special education, child development and family science, human resource management (human service track), or criminal justice.
4. ___ All Supervisors of case management staff have successfully completed the Department of Human Services approved Wraparound Certification training, or are in "Provisionally Certified" status of successfully completing Wraparound Certification training within twelve months of beginning to provide case management.
5. ☐ All Supervisors of case management staff shall maintain Wraparound Certification status through attending a Department of Human Services approved Wraparound Recertification training at least once every two years.

I attest that this provider met the above requirements on ____________________ (Month/Day/Year).

______________________________ Provider Facility/Organization Name
______________________________ Street Address
______________________________ City,State, Zip Code

____________________________ ________________________
Signature Date

____
Printed Name of Authorized Representative

Please sign and return by Email to NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956, ATT: NDM Provider Enrollment

GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES

LONG TERM CARE

Provider Name (printed) ____________________ NPI ____________________

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group provider has met the following requirement:

1. ☐ Has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled persons.

I attest that this provider met the above requirement on ____________________ (Month/Day/Year).

________________________________Provider Facility/Organization Name
________________________________Street Address
________________________________City, State, Zip Code

Signature of Authorized Representative ____________________ Date ____________________

Printed Name of Authorized Representative

Please sign and return by Email to NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956, ATT: NDM Provider Enrollment

GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES
HIGH RISK PREGNANT WOMEN AND INFANTS

______________________ ______________________
Provider Name (printed) NPI

Please note that you have requested enrolling as a Case Management provider; however, Medical Services needs confirmation that you have the appropriate training or background as required by the Medical Services Division policies or Medicaid State Plan requirements.

This group has met all the following requirements:

(CHECK ALL THAT APPLY):

1. ☐ Has at least six months experience in delivering services in a community or home setting.
2. ☐ Has the ability to coordinate prenatal care services for individuals, develop relationships with health care and other area agencies in the particular geographical area they are serving, demonstrate experience in assessing the needs of pregnant women and developing case management plans based on the needs of clients and must demonstrate the ability to evaluate an at risk pregnant woman's progress in obtaining appropriate medical care and other needed services.
3. ☐ All case management staff supervisors have a minimum of a degree in social work, nursing, education, and have at least three years experience in service delivery and supervision.
4. ☐ Has in place a training process that will ensure that staff have adequate knowledge relating to high-risk pregnancy, parenting and other important issues.
5. ☐ Has the ability to provide 24 hour, 7 day a week crisis services to eligible women who are in need of emergency case management services.
6. ☐ Has at least one practitioner who possesses the appropriate training or background as required by the Targeted Case Management State Plan.

I attest that this provider met the above requirements on ______________ (Month/Day/Year).

______________________ Provider Facility/Organization Name
______________________ Street Address
______________________ City, State, Zip Code

______________________ ______________
Signature of Authorized Representative Date

____
Printed Name of Authorized Representative

Please sign and return by Email to NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956, ATT: NDM Provider Enrollment

Revision Date 4/28/2021

GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES
SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS EMOTIONAL DISTURBANCE (SED)

Provider Name (printed) ______________________ **NPI** ______________________

Please fill out this form to confirm required training or backgroud requirements for enrollment as a Targeted Case Management provider. Requirements are per Medical Services Division policies or Medicaid State Plan requirements.

This group provider meets all the following requirements (#6 is needed if the group provider is a North Dakota federally recognized Indian Tribe or Indian Tribal Organization): CHECK ALL THAT APPLY

1. ☐ This provider can be available 24 hours, 7 days a week to individuals who need emergency case management services.
2. ☐ All Supervisors of case management staff have a bachelor's degree.
3. ☐ All individuals providing targeted case management have reviewed the competencies or standards of practice in one of the following:
   a. The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care:
      - SAMHSA Core Competencies for Integrated Care

   OR

   b. The Case Management Society of America standards of practice.
      - Case Management Society Standards of Practice
4. ☐ All individuals providing case management have general knowledge, training and/or experience working with individuals with SMI and/or SED.
5. ☐ All Individuals providing case management will either:
   a. Have a master's degree, OR
   b. Have a bachelor's degree AND two years of experience working with special population groups[2] in a direct care setting; OR
   c. Have at least five years of experience working with individuals with SMI/SED in a supervised, clinical setting.
6. ☐ All Individuals providing case management who are employed by North Dakota federally recognized Indian Tribe or Indian Tribal Organizations will possess the necessary cultural sensitivity and background knowledge to provide appropriate services to the Native American population served.

I attest that this provider met the above requirem ε nts on ______________ (Month/Day/Year)

______________________ Provider Facility/Organization Name
______________________ Street Address
______________________ City, State, Zip Code

______________________ Signature of Authorized Representative

______________________ Date

______________________ Printed Name of Authorized Representative

Please sign and return by Email to NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956

[2] Special population groups include nursing home or assisted living residents, youth in psychiatric treatment centers or residential facilities, individuals in substance use treatment facilities, individuals in mental health/substance use facilities, and experience working in hospitals with youth and/or adults with serious mental illness or serious emotional disturbance. This list is not exhaustive.

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	**Helpful Links**	**Submitted**
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. Home Health Agency License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
7. CMS Certification Letter		
8. Medicare EOB		
9. NPI prinout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	025-Agencies
SPECIALTY	082-Home Health Agency
TAXONOMY	251E00000X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Hospice (025 - 454)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
	Only 1 service location may be enrolled per Medicaid ID.
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**

Please Provide your Medicare ID:

Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES

State Abbv: **Please Provide your Other State Medicaid ID:**

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — **If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.**

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

7. What is the name and Medicaid ID, Application Tracking Number, or NPI of the medical director or attending doctor which will be on your claims? ***(Institutional claims require an attending be enrolled and entered on claims for processing. The "attending" can be either a medical director or attending/referring doctor. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.)***

Name: **Medicaid ID/ATN/NPI:**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment				
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.			Helpful Links	Submitted
1. Coversheet for Fax/Email			Coversheet for Fax/Email	
2. Group Application Checklist				
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:		W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)			What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.			IRS Tax Exempt Letter for Government Agencies	
6. Hospice License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License #	Issued:	Expires:		
7. CMS Certification (Survey)				
8. Benefit Elect Form				
9. NPI prinout from the NPPES Website			NPPES Website	
10. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:		SFN 661 (12-2022)	
10a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661			
11. SFN 1168 (8-2020)			Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs				
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.				
1. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:		SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	025-Agencies
SPECIALTY	454-Hospice Care, Community Based
TAXONOMY	251G00000X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Local Education Agency (LEA) Special Education (025 - 397)
Individualized Education Program (IEP)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ **YES** ☐ **NO**

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ **YES** ☐ **NO**

If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ **YES** ☐ **NO**

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ **YES** ☐ **NO**

5a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

6. Will you be providing ABA (Applied Behavior Analysis) services? ☐ **YES** ☐ **NO**

7. Will you be providing Rehab Services services? ☐ **YES** ☐ **NO**
If yes, Please review the ND Medicaid State Plan for Rehabilitative Services.

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	**Enter Initials below (required for enrollment)**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Speech Therapy License. License must be from one of your rendering Speech Therapy practitioners, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 9 (5-2021) (Required only if you answered Yes to question 7 above - providing Rehab Services)	SFN 9 (5-2021)	
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	025-Agencies
SPECIALTY	397-Local Education (LEA)/Special Education
TAXONOMY	251300000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Local Education Agency (LEA) Special Education (025 - 397)
Non-Individualized Education Program (IEP) School Based Services

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

5a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

6. Will you be providing ABA (Applied Behavior Analysis) services? ☐ YES ☐ NO

7. Will you be providing Rehab Services services? ☐ YES ☐ NO
If yes, Please review the ND Medicaid State Plan for Rehabilitative Services.

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	**Enter Initials below (required for enrollment)**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Speech Therapy License. License must be from one of your rendering Speech Therapy practitioners, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
8. NPI prinout from the NPPES Website — NPI cannot be the same NPI used for an IEP enrollment.	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 9 (5-2021) (Required only if you answered Yes to question 7 above - providing Rehab Services)	SFN 9 (5-2021)	
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

PROVIDER TYPE	025-Agencies
SPECIALTY	397-Local Education (LEA)/Special Education
TAXONOMY	251300000X

Section 4: Enrollment Effective Date

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Private Duty Nursing (025 - 499)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
Please Provide your Medicare ID:
Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

8a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment			
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
3. List of Service Locations (Required if you answered Yes to question 3 above)			
4. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.		IRS Tax Exempt Letter for Government Agencies	
7. RN/LPN License. License must be from one of your rendering RN/LPN practitioners, must cover the effective date below, and must not be expired. License #	Issued: Expires:		
8. NPI prinout from the NPPES Website		NPPES Website	
9. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only			
11. SFN 1168 (8-2020)		Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs			
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.			
12. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	025-Agencies
SPECIALTY	499-Nursing Care
TAXONOMY	251J00000X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist

General Ambulatory Health Care Facility (026)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
   If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Are you providing Medicare Diabetes Prevention Program (MDPP) Services? ☐ YES ☐ NO

7. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

8. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

9. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   9a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering MD practitioners, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
8. PCP Questionnaire — *Required for the following Specialties: 503-Single Specialty (193400000X) 359-Clinic/Center (261Q00000X)*	PCP Questionnaire	
9. NPI prinout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		
12. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
12a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
12b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
13. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	
TAXONOMY	

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Applied Behavior Analysis (ABA) (026 - 026)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ **YES** ☐ **NO**

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ **YES** ☐ **NO** — **If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.**

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ **YES** ☐ **NO**

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ **YES** ☐ **NO**

5a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	**Enter Initials below (required for enrollment)**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	**Helpful Links**	**Submitted**
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering practitioners, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	026-Adolescent and Children Mental Health
TAXONOMY	261QM0855X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist

Ambulatory Surgical Center Institutional Billing* (026 - 089)

***Ambulatory Surgical Centers must bill institutional fees in separate records from professional fees. Submit a separate application and checklist for institutional and professional billing. This checklist is used for the ASC Institutional Billing application.**

Click Here for the ASC professional billing checklist

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES

Please Provide your Medicare ID:

Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES

State Abbv: **Please Provide your Other State Medicaid ID:**

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

8a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

9. What is the name and Medicaid ID, Application Tracking Number, or NPI of the Attending physician which will be on your claims?
(Institutional claims require an attending be enrolled and entered on claims for processing. The "attending" can be either a medical director or attending/referring doctor. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.)

Name: **Medicaid ID/ATN/NPI:**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.				Helpful Links	Submitted
1. Coversheet for Fax/Email				Coversheet for Fax/Email	
2. Group Application Checklist					
3. List of Service Locations (Required if you answered Yes to question 3 above)					
4. W-9 (10-2018)	Printed Name of Signing Managing Employee:			W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)				What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.				IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your attending MD practitioners, must cover the effective date below, and must not be expired.					
License #	Issued:		Expires:		
8. NPI prinout from the NPPES Website				NPPES Website	
9. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:			SFN 661 (12-2022)	
9a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661				
10. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only					
11. SFN 1168 (8-2020)				Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs					
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.					
12. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:			SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	089-Ambulatory Surgical Center
TAXONOMY	261QA1903X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the ** above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Ambulatory Surgical Center Professional Billing* (026)

*Ambulatory Surgical Centers must bill institutional fees in separate records from professional fees. Submit a separate application and checklist for institutional and professional billing. This checklist is used for the ASC Professional Billing application.
Click Here for the ASC institutional checklist.

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

2. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

7a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment					
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.				Helpful Links	Submitted
1. Coversheet for Fax/Email				Coversheet for Fax/Email	
2. Group Application Checklist					
3. List of Service Locations (Required if you answered Yes to question 2 above)					
4. W-9 (10-2018)	Printed Name of Signing Managing Employee:			W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)				What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.				IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering MD practitioners, must cover the effective date below, and must not be expired. License #	Issued:		Expires:		
8. NPI prinout from the NPPES Website				NPPES Website	
9. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:			SFN 661 (12-2022)	
9a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661				
10. Claim (Required if you answered Yes to question 3 above) Claims submitted are for Enrollment Purposes Only					
11. SFN 1168 (8-2020)				Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs					
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.					
12. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:			SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities	
SPECIALTY/Taxonomy (Please Choose One)	☐ 503-Single Specialty 193400000X	☐ 504-Multi-Specialty 193200000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the ** above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Dental Group (026)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO

If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?

If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	**Enter Initials below (required for enrollment)**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.			Helpful Links	Submitted
1. Coversheet for Fax/Email			Coversheet for Fax/Email	
2. Group Application Checklist				
3. List of Service Locations (Required if you answered Yes to question 1 above)				
4. W-9 (10-2018)	Printed Name of Signing Managing Employee:		W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)			What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.			IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your MD practitioners, must cover the effective date below, and must not be expired. License #	Issued:	Expires:		
8. NPI printout from the NPPES Website			NPPES Website	
9. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:		SFN 661 (12-2022)	
9a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661			
10. Claim (Required if you answered Yes to question 2 above) Claims submitted are for Enrollment Purposes Only				
11. SFN 1168 (8-2020)			Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs				
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.				
12. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:		SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities	
SPECIALTY/Taxonomy (Please Choose One)	☐ 437-Dental Clinic 261QD0000X	☐ 503-Single Specialty 193400000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Group Application Checklist
FQHC (Federally Qualified Health Center)* (026 - 361)

***FQHCs cannot bill services for Optometrists, Chiropractors, or Podiatrists through this enrollment. These services must be billed under a separate enrollment for an FQHC Optometrist/Chiropractic/Podiatrist Billing Group with either taxonomy 193400000X or 193200000X.**

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
	Only 1 service location may be enrolled per Medicaid ID.
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**

Please Provide your Medicare ID:

Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — **If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.**

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2). List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. License. License must be from one of your MD practitioners, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
7. CMS Certification Letter		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 2 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	361-Federally Qualified Health Center
TAXONOMY	261QF0400X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the ** above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
FQHC Billing Group for Optometrist, Chiropractor, and/or Podiatrist* (026)

***All FQHCs must be enrolled with Medicare before enrolling with ND Medicaid.**
FQHCs can only use this checklist to enroll for services provided by Optometrists, Chiropractors, and/or Podiatrists. For FQHC services not provided by Optometrists, Chiropractors, or Podiatrists, use the regular FQHC checklist with taxonomy 261QF0400X.

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO

If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering practitioners, must cover the effective date below, and must not be expired. License # Issued: Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 2 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities	
SPECIALTY/Taxonomy (Please Choose One)	☐ 503-Single Specialty 193400000X	☐ 504-Multi-Specialty 193200000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the ** above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Group Application Checklist
Methadone/Suboxone (026 - 509)

Click Here for the Medication Assisted Treatment (MAT) Policy

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
   If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   7a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

8. Have you had full and continuous SAHMSA Accreditation since October 23, 2018? ☐ YES ☐ NO
   (If yes, submit a copy of your SAHMSA Accreditations going back to October 23, 2018)

9. Please select the Medication Assisted Treatment or Treatments you will be providing:
   ☐ Methadone ☐ Suboxone

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents Continued

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. SAMHSA - Required if you are providing Methadone *(It is the responsibility of the provider to keep updated certification information on file with the state by submitting a copy of the updated certificate to provider enrollment each time it is renewed)* Effective: Expires:		
8. X DEA of a practitioner - Required if you are providing Suboxone *(It is the responsibility of the provider to submit the initial X DEA for each practitioner and keep updated X DEA information on file with the state for each practitioner by submitting a copy of the X DEAs to provider enrollment each time they are renewed)* X DEA Number: Effective: Expires:		
9. NPI prinout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. SFN 1168 (8-2020)	Simplified Instructions based on	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	509-Methadone (this specialty/taxonomy combination is for Methadone and/or Suboxone)
TAXONOMY	261QM2800X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

Section 4: Enrollment Effective Date Continued

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. **You must include a copy of the claim and medical records with your application documents.**

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.

Requested Enrollment Effective Date	

Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Group Application Checklist
Mental Health Rehab Group (026 - 360)

Are you a Mental Health "Rehab" group?
Click Here for the ND Medicaid State Plan for Rehabilitative Services.

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   8a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 2: Questions Continued

Question		
9. Does the enrolling facility provide residential or inpatient services to individuals with mental diseases? Mental diseases are diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of intellectual disability, senility and organic brain syndrome. Substance use disorders are considered a mental disease. If Yes, answer questions 9a-9c below.	☐ Yes	☐ No
9a. Does your organization or governing body have any other facilities that provide residential or inpatient services to individuals with mental diseases? If yes, provide a list with the addresses of each location.	☐ Yes	☐ No
9b. How many total beds does your facility have? If you have more than one facility, provide the number of beds at each. This question is asking about number of beds, not number of rooms. If there are rooms with more than one bed, each bed must be counted.)		
9c. How many of the total beds are used for services for individuals with mental diseases? If you have more than one location, provide number of beds at each location used for behavioral health services		

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering practitioners, must cover the effective date below, and must not be expired. License # Issued: Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661		
10. Rehab Questionnaire	Rehab Questionnaire	
11. SFN 9 (5-2021)	SFN 9 (5-2021)	
12. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		
13. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
13a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
13b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
14. SFN 615 (6-2023) Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	360-Mental Health (Incl. Comm Mntl Hlth)
TAXONOMY	261QM0801X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Physical Therapy Group (026 - 110)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
   If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   8a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked (“affiliated”) to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering Physical Therapists, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	110-Physical Therapy
TAXONOMY	261QP2000X

Section 4: Enrollment Effective Date

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Rehabilitation, Substance Use Disorder (026 - 364)

Click Here for more information about Coverage of Medicaid Addiction Treatment Services

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
   If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   8a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

9. Please indicate which ASAM levels are provided by your program. At such time as your program decides to provide any additional ASAM levels, you must inform the Department in advance and submit the license which covers the ASAM levels provided. Any levels not found in the list below are not covered by ND Medicaid at this time.

   ASAM Levels: ☐ 1 ☐ 2.1 ☐ 2.5 ☐ 3.1 ☐ 3.2 ☐ 3.5 ☐ 3.7

Section 2: Questions Continued

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

10. Do you have Accreditation? (If yes, please submit copy) ☐ YES ☐ NO

11. Does the enrolling facility provide residential or inpatient services to individuals with mental diseases? Mental diseases are diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of intellectual disability, senility and organic brain syndrome. Substance use disorders are considered a mental disease. If Yes, answer questions 11a-11c below.	☐ Yes	☐ No
11a. Does your organization or governing body have any other facilities that provide residential or inpatient services to individuals with mental diseases? If yes, provide a list with the addresses of each location.	☐ Yes	☐ No
11b. How many total beds does your facility have? If you have more than one facility, provide the number of beds at each. (This question is asking about number of beds, not number of rooms. If there are rooms with more than one bed, each bed must be counted.)		
11c. How many of the total beds are used for services for individuals with mental diseases? If you have more than one location, provide number of beds at each location used for behavioral health services		

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Program License (ASAM License) *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # Issued: Expires:		
8. Accreditation (Required if you answered Yes to question 10 above)		
9. NPI prinout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. SFN 9 (5-2021)	SFN 9 (5-2021)	
12. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		

Section 3: Required Documents Continued

12. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
12a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
12b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
13. SFN 615 (6-2023) **Printed Name of Signing Managing Employee:**	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	364-Rehabilitation, Substance Use Disorder
TAXONOMY	261QR0405X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
http://www.nd.gov/dhs/info/mmis/docs/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
026- 268- Rural Health Clinic*

***Rural Health Clinic records cannot be used to bill professional fees. All Hospital Professional fees must be billed under a Hospital Professional Billing Group.**

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   5a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	

Section 3: Required Documents Continued

6. License. License must be from one of your MD practitioners, must cover the effective date below, and must not be expired.		
License # / Issued: / Expires:		
7. CMS RHC Certification Letter		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	268-Rural Health Clinic
TAXONOMY	261QR1300X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the ** above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	
Click Here to find more information on Effective Dates and Retro Effective Date Policies			

Revision **8/22/2023**

Group Application Checklist

Rehabilitation, Substance Use Disorder Unit (027 - 623)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   7a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 2: Questions Continued

8. Does the enrolling facility provide residential or inpatient services to individuals with mental diseases? Mental diseases are diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of intellectual disability, senility and organic brain syndrome. Substance use disorders are considered a mental disease. **If Yes, answer questions 8a-8e below.**		☐ Yes	☐ No
	8a. How many total beds does your facility have (all beds, not just beds used for individuals with mental diseases)? If you have more than one facility, provide the number of beds at each. (This question is asking about number of beds, not number of rooms. If there are rooms with more than one bed, each bed must be counted.)		
	8b. Does your facility have specific beds or units that are allocated for services for individuals with mental diseases?	☐ Yes	☐ No
	8c. How many beds are typically used for inpatient services for individuals with mental diseases?		
	8d. Does your facility ever adjust the number of beds allocated for inpatient services for individuals with mental diseases?	☐ Yes	☐ No
	8e. Does your organization or governing body have any other facilities that provide residential or inpatient services to individuals with mental diseases? **If Yes, provide a list with the addresses of each location.**	☐ Yes	☐ No

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 2 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Hospital License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
8. Unit License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
9. NPI prinout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. Claim (Required if you answered Yes to question 3 above) Claims submitted are for Enrollment Purposes Only		

Section 3: Required Documents Continued

12. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		

13. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:		SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	027- Hospital Units
SPECIALTY	364-Rehabilitation, Substance Use Disorder Unit
TAXONOMY	276400000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist

Swingbed (027 - 196)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
Please Provide your Medicare ID:
Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO **If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.**

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

7a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

8. What is the name and Medicaid ID, Application Tracking Number, or NPI of the Attending physician which will be on your claims?
(Institutional claims require an attending be enrolled and entered on claims for processing. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.)
Name: **Medicaid ID/ATN/NPI:**

Section 2: Questions Continued

Question	Yes	No
9. Does the enrolling facility provide residential or inpatient services to individuals with mental diseases? Mental diseases are diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of intellectual disability, senility and organic brain syndrome. Substance use disorders are considered a mental disease. If Yes, answer questions 9a-9e below.	☐ Yes	☐ No
9a. How many total beds does your facility have (all beds, not just beds used for individuals with mental diseases)? If you have more than one facility, provide the number of beds at each (This question is asking about number of beds, not number of rooms. If there are rooms with more than one bed, each bed must be counted.)		
9b. Does your facility have specific beds or units that are allocated for services for individuals with mental diseases?	☐ Yes	☐ No
9c. How many beds are typically used for inpatient services for individuals with mental diseases?		
9d. Does your facility ever adjust the number of beds allocated for inpatient services for individuals with mental diseases?	☐ Yes	☐ No
9e. Does your organization or governing body have any other facilities that provide residential or inpatient services to individuals with mental diseases? If yes, provide a list with the addresses of each location.	☐ Yes	☐ No

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 2 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Hospital License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # Issued: Expires:		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 3 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	027- Hospital Units
SPECIALTY	196-Swingbed
TAXONOMY	275N00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

[Click Here to find more information on Effective Dates and Retro Effective Date Policies]

Revision **8/22/2023**

Group Application Checklist
Hospital Institutional Billing* (028)

*Hospitals must bill institutional fees in separate records from professional fees. Submit a separate application and checklist for institutional and professional billing. This checklist is used for the Hospital Institutional Billing application. Click Here for the hospital professional billing checklist.

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
 Please Provide your Medicare ID:
 Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
 State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
 If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
 Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
 If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
 If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
 List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
 8a. If Yes, how many Board Members do you have?
 If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

9. What is the name and Medicaid ID, Application Tracking Number, or NPI of the Attending physician which will be on your claims?
 (Institutional claims require an attending be enrolled and entered on claims for processing. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.)
 Name: Medicaid ID/ATN/NPI:

Section 2: Questions Continued

10. Does the enrolling facility provide residential or inpatient services to individuals with mental diseases? Mental diseases are diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of intellectual disability, senility and organic brain syndrome. Substance use disorders are considered a mental disease. **If Yes, answer questions 10a-10e below.**	☐ Yes	☐ No
10a. How many total beds does your facility have (all beds, not just beds used for individuals with mental diseases)? If you have more than one facility, provide the number of beds at each. (This question is asking about number of beds, not number of rooms. If there are rooms with more than one bed, each bed must be counted.)		
10b. Does your facility have specific beds or units that are allocated for services for individuals with mental diseases?	☐ Yes	☐ No
10c. How many beds are typically used for inpatient services for individuals with mental diseases?		
10d. Does your facility ever adjust the number of beds allocated for inpatient services for individuals with mental diseases?	☐ Yes	☐ No
10e. Does your organization or governing body have any other facilities that provide residential or inpatient services to individuals with mental diseases? **If yes, provide a list with the addresses of each location.**	☐ Yes	☐ No

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	**Helpful Links**	**Submitted**
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Hospital License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
8. CLIA (If applicable)		
9. NPI prinout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		
12. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
12a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
12b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
13. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4:
Taxonomy & Enrollment Effective Date

PROVIDER TYPE 028-Hospitals

SPECIALTY

TAXONOMY

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdfpdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist

Hospital Professional Billing* (026)

***Hospitals must bill institutional fees in separate records from professional fees. Submit a separate application and checklist for institutional and professional billing. This checklist is used for the Hospital Professional Billing application. Click Here for the institutional billing checklist.**

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.

Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your MD practitioners, must cover the effective date below, and must not be expired. License # — Issued: — Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 2 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities	
SPECIALTY/Taxonomy (Please Choose One)	☐ 503-Single Specialty 193400000X	☐ 504-Multi-Specialty 193200000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the ** above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Laboratory (029)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
Please Provide your Medicare ID:
Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
State Abbv: **Please Provide your Other State Medicaid ID:**

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		What is the CP575/147C?	

Section 3: Required Documents Continued

5. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. CLIA CLIA # | Issued: | | Expires: |		
7. License/Certification - Required if license/ceritification is required by your state *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # | Issued: | | Expires: |		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) | Printed Name of Signing Managing Employee: |	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) | Printed Name of Signing Managing Employee: |	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	029-Laboratories
SPECIALTY	
TAXONOMY	

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist

Skilled Nursing Facility (031 - 269)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Field	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
   If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   6a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

7. What is the name and Medicaid ID, Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? *(Institutional claims require an attending be enrolled and entered on claims for processing. The "attending" can be either a medical director or attending/referring doctor. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.)*
   Name: Medicaid ID/ATN/NPI:

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	

Section 3: Required Documents Continued

Item	Link	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. Nursing Facility License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # / Issued: / Expires:		
7. CLIA License # / Issued: / Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 509 (5-2021) — (Required for Out of State providers = Answered yes to question 2 above) Date of service must match the enrollment effective date below and match the date of service on the Medical Notes.	SFN 509 (5-2021)	
10a. Copy of Claim — (Required for Out of State providers = Answered yes to question 2 above) Claims submitted are for Enrollment Purposes Only.		
10b. Medical Notes — (Required for Out of State providers = Answered yes to question 2 above) Medical Notes submitted are for Enrollment Purposes Only.		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	031-Nursing & Custodial Care Facilities
SPECIALTY	269-Skilled Nursing Facility
TAXONOMY	31400000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Psychiatric Residential Treatment Facility (032 - 258)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
Please Provide your Medicare ID:
Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
State Abbv: **Please Provide your Other State Medicaid ID:**

3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

7a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

8. What is the name and Medicaid ID, Application Tracking Number, or NPI of the medical director or attending practitioner which will be on your claims? *(Institutional claims require an attending be enrolled and entered on claims for processing. The "attending" can be either a medical director or attending/referring doctor)*
Name: **Medicaid ID/ATN/NPI:**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	

Section 3: Required Documents Continued

2. Group Application Checklist		
3. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. PRTF License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
7. Accreditation		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. SFN 509 (5-2021) — (Required for Out of State providers = Answered yes to question 3 above) Date of service must match the enrollment effective date below.	SFN 509 (5-2021)	
10a. Copy of Claim — (Required for Out of State providers = Answered yes to question 3 above) Claims submitted are for Enrollment Purposes Only.		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Emloyee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	032-Residential Treatment Facilities
SPECIALTY	258-Psychiatric Residential Treatment Facility
TAXONOMY	323P00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
QRTP (032 - 264)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Field	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   7a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	Enter Initials below (required for enrollment)

Section 3: Required Documents Continued

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. QRTP License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
7. NPI prinout from the NPPES Website	NPPES Website	
8. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
8a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
9. Claim (Required if you answered Yes to question 3 above) Claims submitted are for Enrollment Purposes Only		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	032-Residential Treatment Facilities
SPECIALTY	264-QRTP, Qualified Residential Treatment Program
TAXONOMY	322D00000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
QRTP OLP Billing Group (026/504)

This enrollment is optional. Use only if your QRTP wants to enroll separately for services provided by Other License Practitioners (OLPs). These OLP services would be billed under this record under the group taxonomy 193200000X. If you choose to enroll OLP services separately, please also make sure you are enrolled under a regular QRTP record (with taxonomy 322D00000X) so you can bill services provided by non-OLPs.
Click Here for the regular QRTP checklist.

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

3. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO **If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.**

4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

5. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

6a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.	**Enter Initials below (required for enrollment)**

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License. License must be from one of your rendering practitioners, must cover the effective date below, and must not be expired. License # Issued: Expires:		
8. NPI printout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 2 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	026- Ambulatory Health Care Facilities
SPECIALTY	504-Multi-Specialty
TAXONOMY	193200000X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the ** above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Sole Proprietor Checklist*

*** Use this Checklist only if the sole proprietor wants to bill ND Medicaid under his/her SSN. If he/she wants to bill under the Tax ID of the business, use the applicable group checklist.**

Have Questions?
Click Here for FAQs and More Resources

All Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Service Location	
Billing Address	
Mailing Address	
Work Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. How are you filing taxes with the IRS? ☐ **Filing under SSN** ☐ **Filing under EIN (Tax ID)**

Sole Proprietor's filing taxes under an SSN submit an Individual online application and the documents indicated below
Sole Proprietor's filing taxes under a business Tax ID (EIN) submit a Group online application and use the Group Checklist that matches the Provider Type/Specialty/Taxonomy needed to bill the services provided by the business.

2. How many Managing Employees (authorized to sign on behalf of the business) do you have?

If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form.				Helpful Links	Submitted
1. Coversheet for Fax/Email				Coversheet for Fax/Email	
2. Sole Proprietor Checklist					
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:			W-9 (10-2018)	
4. License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)*					
License #	Issued:		Expires:		
5. DEA *(Only Required for Prescribers)*					
DEA #	Issued:		Expires:		
6. NPI prinout from the NPPES Website				NPPES Website	
7. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:			SFN 661 (12-2022)	
7a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661				

Section 3: Required Documents Continued

8. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
8a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		

9. SFN 615 (6-2023)	Page 4 of the SFN 615 form must be signed & dated by the Individual Provider who is applying as a Sole Proprietor.	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE ____________________

SPECIALTY ____________________

TAXONOMY ____________________

What is a Taxonomy? Click Here to find more information on Taxonomies

Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date.**The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the ** above.**

Requested Enrollment Effective Date	

Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Sole Proprietor Checklist*
Autism Waiver (039)

*** Use this Checklist only if the sole proprietor wants to bill ND Medicaid under his/her SSN. If he/she wants to bill under the Tax ID of the business, use the applicable group checklist.**

Have Questions?
Click Here for FAQs and More Resources

All Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Service Location	
Billing Address	
Mailing Address	
Work Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. How are you filing taxes with the IRS? ☐Filing under SSN ☐Filing under EIN (Tax ID)

Sole Proprietor's filing taxes under an SSN submit an Individual online application and the documents indicated below
Sole Proprietor's filing taxes under a business Tax ID (EIN) submit a Group online application and use the Group Checklist that matches the Provider Type/Specialty/Taxonomy needed to bill the services provided by the business.

2. How many Managing Employees (authorized to sign on behalf of the business) do you have?

If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form.				Helpful Links	Submitted
1. Coversheet for Fax/Email				Coversheet for Fax/Email	
2. Sole Proprietor Checklist					
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:			W-9 (10-2018)	
4. License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)*					
License #	Issued:		Expires:		
5. NPI printout from the NPPES Website				NPPES Website	
6. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:			SFN 661 (12-2022)	
6a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661				

Section 3: Required Documents Continued

7. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
7a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
8. SFN 615 (6-2023) — Page Āof the SFN 615 form must eą signed Ā dated Āy the Individual Provider who is applying as a Sole ProprietorĀ	SFN 615 (6-2023)	

Proof of Insurance is not required for any applicationĀIf proof of insurance is suĀmitted with an applicationĀit will eą deleted from the file. It remains teą Ārovider's reso nsibility to ensure taăt the necessary insurance is in place, u t proof of insurance is not required to be suĀmitted for any application.

Section : Enrom ent EffectiĀe Date

PROVIDER TYPE	. 3. -Developmental Disabilities
SPECIALTY	508-Service Management
TAXONOMY	A taxonomy code is not required for tĀis provider tyĀe/specialty combination

Program Design & Monitoring and Skills Training are specialties only available for entities which are enrolled under the Applied Behavior Analysis Application Checklist.

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

****If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of _____________. Refer to the ** above.**

Requested Enrollment Effective Date	

Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Durable Medical Equipment (033)

Verify the service you are providing is covered by ND Medicaid before completing the application
Click Here for the Manual for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	
Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID for the following Specialties:
1. Durable Medical Equipment & Medical Suppliers = Taxonomy 332B00000X
2. Prosthetic/Orthotic Supplier = Taxonomy 335E00000X

Field	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   3a. If Yes, will you be implementing or shipping to North Dakota or will the services be provided on-site?
   ☐ Implementing/Shipping ☐ On-Site

4. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO
   If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   8a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 4 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License/Certification *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
8. North Dakota Wholesale License - Issued by the ND Board of Pharmacy *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
9. NPI printout from the NPPES Website	NPPES Website	
10. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
10a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
11. SFN 509 (5-2021) — (Required for Out of State providers = Answered yes to question 3 above) Date of service must match the enrollment effective date below.	SFN 509 (5-2021)	
11a. Copy of Claim — (Required for Out of State providers = Answered yes to question 3 above) Claims submitted are for Enrollment Purposes Only.		
12. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
12a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
12b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
13. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	033-Suppliers
SPECIALTY	
TAXONOMY	

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

Section 4: Taxonomy & Enrollment Effective Date Continued

☐ This application is associated with an emergency service. We are requesting the date of _______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	
Click Here to find more information on Effective Dates and Retro Effective Date Policies			

Revision 8/22/2023

Group Application Checklist
Pharmacy (033)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you an Out of State Provider (Service location outside North Dakota, Minnesota, Montana, or South Dakota?) ☐ YES ☐ NO

4. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

6. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   7a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	

Section 3: Required Documents Continued

4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
6. License/Certification *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # / Issued: / Expires:		
7. NPI prinout from the NPPES Website	NPPES Website	
8. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
8a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
9. SFN 509 (5-2021) — (Required for Out of State providers = Answered yes to question 3 above) Date of service must match the enrollment effective date below.	SFN 509 (5-2021)	
9a. Copy of Claim — (Required for Out of State providers = Answered yes to question 3 above) Claims submitted are for Enrollment Purposes Only.		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	
12. SFN 1169 (3-2018) — Printed Name of Signing Managing Employee:	SFN 1169 (3-2018)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	033-Suppliers
SPECIALTY	
TAXONOMY	

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Hearing Aid Specialists (033 - 383)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES
Please Provide your Medicare ID:
Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
State Abbv: **Please Provide your Other State Medicaid ID:**

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

8a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents Continued

The documents requested below must be returned to the Department in order to process your enrollment		
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. License/Certification *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	033-Suppliers
SPECIALTY	383-Hearing Aid Equipment
TAXONOMY	332S00000X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of _____________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Ambulance (034)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicare? ☐ NO ☐ YES **Medicare Enrollment is required**
   Please Provide your Medicare ID:
   Is your Medicare Record up to date? ☐ NO ☐ YES

2. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

3. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO
   If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).
   Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

4. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO
   If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

5. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

6. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

7. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

8. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   8a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form.

Document	Helpful Links	Submitted
Outdated versions of forms will not be accepted. 1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 3 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. Ambulance License *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)* License # — Issued: — Expires:		
8. NPI prinout from the NPPES Website	NPPES Website	
9. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
9a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
10. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment Purposes Only		
11. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
11a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
12. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE SPECIALTY/Taxonomy (Please Choose One)	034-Transportation Services ☐ 511-Ambulance-Land Transport 3416L0300X	☐ 510-Ambulance-Air Transport 3416A0800X

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days*** prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Group Application Checklist
Autism Waiver (039)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Field	Value
Application Tracking #	
Provider Name	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in the same record as out of state service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided at each location.

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

5a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 1 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	

Section 3: Required Documents Continued

7. SFN 661 (12-2022)	Printed Name of Signing Managing Employee:		SFN 661 (12-2022)	
7a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661			

8. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
8a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
8b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		

9. SFN 615 (6-2023)	Printed Name of Signing Managing Employee:		SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Specialty & Enrollment Effective Date

PROVIDER TYPE	039-Developmental Disabilities
SPECIALTY	
TAXONOMY	

Specialties Respite, Self-Directed Supports, Assistive Technology, & Service Management only.
Specialties Program Design & Monitoring and Skills Training would be enrolled under the Applied Behavior Analysis (ABA) checklist.

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Basic Care (043)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	

Only 1 service location may be enrolled per Medicaid ID.

Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES
   State Abbv: Please Provide your Other State Medicaid ID:

2. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO — If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

3. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

4. How many Managing Employees (authorized to sign on behalf of the business) do you have?
   If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
   List must contain First Names, Last Names, Dates of Birth, and SSNs

5. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO
   5a. If Yes, how many Board Members do you have?
   If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

Sectio 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.		Helpful Links	Submitted
1. Coversheet for Fax/Email		Coversheet for Fax/Email	
2. Group Application Checklist			
3. W-9 (10-2018)	Printed Name of Signing Managing Employee:	W-9 (10-2018)	
4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)			

Section 3: Required Documents Continued

Item					Link	
5. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.					IRS Tax Exempt Letter for Government Agencies	
6. Basic Care License. License must cover the effective date below, and must not be expired. *(It is the responsibility of the provider to keep updated licensure information on file with the state by submitting a copy of the license to provider enrollment each time it is renewed)*						
License #	Issued:		Expires:			
7. CLIA						
License #	Issued:		Expires:			
8. NPI prinout from the NPPES Website					NPPES Website	
9. SFN 661 (12-2022)	**Printed Name of Signing Managing Employee:**				SFN 661 (12-2022)	
9a. Bank Letter/Voided Check	Must match the Information provided on the SFN 661					
10. SFN 1168 (8-2020)					Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs						
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.						
11. SFN 615 (6-2023)	**Printed Name of Signing Managing Employee:**				SFN 615 (6-2023)	
12. SFN 308 (5-2005)	**Printed Name of Signing Managing Employee:**				SFN 308 (5-2005)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Enrollment Effective Date

PROVIDER TYPE	043-Basic Care
SPECIALTY	079-Basic Care Facility
TAXONOMY	311Z00000X

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

***If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.**

☐ **This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.**

Requested Enrollment Effective Date			
Printed Name of Person Requesting the Effective Date		**Date**	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision **8/22/2023**

Group Application Checklist
Indian Health Services (047)

Have Questions?
Click Here for FAQs and More Resources

All 4 Sections and Fields are Required unless specifically marked as not required

Section 1: Identifying Information

Application Tracking #	
Provider Name	
Organizational NPI #	
Service Address	
Billing Address	
Mailing Address	
Facility Phone	
Contact Person	
Phone	
Email	

Section 2: Questions

1. Do you have a 638 Contract? ☐Yes ☐No

1a. If yes, please submit the portion of your contract which indicates the services you are contracted to provide.

2. Are you Enrolled in Medicare? ☐ NO ☐ YES

Please Provide your Medicare ID:

Is your Medicare Record up to date? ☐ NO ☐ YES

3. Are you Enrolled in Medicaid in another State? ☐ NO ☐ YES

State Abbv: **Please Provide your Other State Medicaid ID:**

4. Are you enrolling any additional service locations not listed above at this time? ☐ YES ☐ NO

If yes, please include a list with the addresses of all service locations being enrolled (must have the same Provider Type, NPI, EIN, and billing address).

5. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?) ☐ YES ☐ NO

If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be submitted with your enrollment documents. The date of service on the claim must support your requested effective date for enrollment.

6. Are you exempt from FEDERAL taxes? ☐ YES ☐ NO

If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.

7. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? (Interest may be direct or indirect) ☐ YES ☐ NO

8. How many Managing Employees (authorized to sign on behalf of the business) do you have?
If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).
List must contain First Names, Last Names, Dates of Birth, and SSNs

9. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? ☐ YES ☐ NO

9a. If Yes, how many Board Members do you have?
If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).

I have read and acknowledge that I understand the following: Affiliations (separate individual enrollments) are required. In order to bill on a professional claim form, the billing group (clinic, practice, etc.) and the individual rendering provider/s must be enrolled. Also, the rendering provider's record must be linked ("affiliated") to the billing provider record in the system. For all rendering providers who are not actively enrolled in ND Medicaid, individual applications should be submitted before the group application is approved.

Enter Initials below (required for enrollment)

Section 3: Required Documents

The documents requested below must be returned to the Department in order to process your enrollment

Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted.	Helpful Links	Submitted
1. Coversheet for Fax/Email	Coversheet for Fax/Email	
2. Group Application Checklist		
3. List of Service Locations (Required if you answered Yes to question 4 above)		
4. W-9 (10-2018) — Printed Name of Signing Managing Employee:	W-9 (10-2018)	
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?	
6. IRS Tax Exempt Letter (Required if you answered Yes to question 6 above) If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter cannot be substituted. The letter must be issued by the IRS.	IRS Tax Exempt Letter for Government Agencies	
7. NPI prinout from the NPPES Website	NPPES Website	
8. SFN 661 (12-2022) — Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
8a. Bank Letter/Voided Check — Must match the Information provided on the SFN 661		
9. Claim (Required if you answered Yes to question 5 above) Claims submitted are for Enrollment Purposes Only		
10. SFN 1168 (8-2020)	Simplified Instructions based on FAQs	
10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
11. SFN 615 (6-2023) — Printed Name of Signing Managing Employee:	SFN 615 (6-2023)	

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

Section 4: Taxonomy & Enrollment Effective Date

PROVIDER TYPE	047-Indian Health Services
SPECIALTY	
TAXONOMY	

What is a Taxonomy? Click Here to find more information on Taxonomies

Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf

Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. **The Department will not make changes to that date once the application is approved** and any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a **complete** application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

*If this application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.

☐ This application is associated with an emergency service. We are requesting the date of ______________. Refer to the * above.

Requested Enrollment Effective date			
Printed Name of Person Requesting the Effective Date		Date	

Click Here to find more information on Effective Dates and Retro Effective Date Policies

Revision 8/22/2023

Services Provided Questionnaire

To ensure billing groups are enrolled and using the most appropriate taxonomy code, North Dakota Medicaid is requesting the following questions be answered in regard to the types of services that this facility provides. **Please coordinate with your billing department when supplying the information below.**

Medicaid ID/Application Tracking Number	
Provider Name	
NPI #	

1. Does this facility offer primary care provider services, where the majority of the patient's health care needs can be met?
   - *Note: See the Primary Care Case Management Program page for more information on primary care provider services.*

   ☐ Yes ☐ No

2. If you answered yes to question 1 above, do you have primary care providers that would like to be listed as primary care providers?

   ☐ Yes ☐ No

Credentialing Contact (Required)	
Credentialing Email (Required)	

Billing Contact (Required)	
Billing Email (Required)	

Date	

North Dakota Medicaid
Provider Questionnaire

Medicaid ID or ATN#:	Provider Name:	Group NPI:

To ensure billing groups are enrolled and using the most appropriate taxonomy code, North Dakota Medicaid is requesting the following questions be answered regarding the types of services that this facility provides. Please coordinate with your billing department when supplying the information below.

1. What are the services being delivered and their scope of coverage?

2. Where will the services be delivered?

3. Who is the target population you would be delivering services to?

4. What is the level of care criteria to receive the service?

5. What types of practitioners are you considering have deliver the service?

6. What are the licensing requirements of the practitioners you are considering to deliver the service?

7. Please provide a brief description of the program.

CONTACT INFORMATION FOR REQUESTOR

Name (Typed or Printed)
Email Address

Date:	

If you should need more room to answer the questions above, please use another piece of paper and attach it. Once the questions are completed please email NDMedicaidEnrollment@noridian.com or fax to (701) 433-5956 ATT: NDM Provider Enrollment and be sure to reference your Application Tracking Number (ATN) or ND Medicaid ID number.

Revision 4/29/2021

Accessed on 1/17/2022: https://innovation.cms.gov/files/x/mdpp_overview_fact_sheet.pdf

Medicare Diabetes Prevention Program (MDPP)

Expanded Model Fact Sheet

The Medicare Diabetes Prevention Program (MDPP) is a behavior change intervention that builds on the success of the CDC's National Diabetes Prevention Program (National DPP). The National DPP is a structured lifestyle intervention that was tested in the Medicare population through an Innovation Center-funded DPP Model Test (Y-USA test). The DPP Model test showed that group-based community sessions can lead to beneficiary weight loss and Medicare savings.[1]

The Prevalence and Cost of Diabetes

Diabetes affects many individuals, negatively impacts health outcomes, and carries high costs. Effective behavior change can reduce the risk of type 2 diabetes.

While Many are At-Risk for Diabetes, Few are Aware

1 in 2 Adults over age 65 have prediabetes[2]

however...

Only 1 in 7 adults aged 65 and older with prediabetes are aware of their condition[2]

Diabetes Prevalence is High and Growing

One in four adults over age 65 have diabetes[3]

and...

Prevalence of diabetes is expected to double by 2050 among adults[4]

The Disease Burdens the System with High Costs

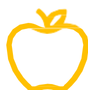
$104B Annual Medicare cost of care for Americans 65+ with diabetes[5]

and...

Adults with diabetes have more ED visits, hospitalizations, and take a larger number of prescription drugs[3]

Program Overview

The goal of MDPP is to help Medicare beneficiaries achieve at least 5% weight loss through behavior change sessions to prevent the onset of type 2 diabetes through practical training in:



Long-term dietary change

Increased physical activity

Behavioral change strategies for weight loss

There are three key groups that participate in the delivery of MDPP services: suppliers, coaches, and beneficiaries.

Suppliers...

- Are hospitals, community organizations, churches, clinics, and other kinds of organizations
- Have full or preliminary CDC DPRP recognition
- Meet program eligibility requirements as described in the *Supplier Requirements Checklist*.
- Deliver up to 2 years of MDPP set of services to eligible Medicare beneficiaries.[6]
- For more on supplier eligibility visit: https://innovation.cms.gov/Files/x/mdpp-supplierreq-checklist.pdf

Coaches...

- Are employees, contractors, or volunteers of an MDPP supplier
- Have a valid National Provider Identifier (NPI) that meet full program eligibility requirements.
- Can be can be clinical or non-clinical professionals trained in the CDC-approved curriculum.[7,8] For more on coach eligibility, visit: https://innovation.cms.gov/Files/fact-sheet/mdpp-coachelig-fs.pdf

Eligible Medicare beneficiaries...

- Are individuals enrolled in Original Medicare (Part B) or Medicare Advantage (Part C), and meet a minimum BMI and 1 of 3 blood test requirements, in addition to other criteria. Beneficiaries with Original Medicare/Fee-for- Service coverage pay no out-of-pocket costs to participate. For more on beneficiary eligibility, visit: https://innovation.cms.gov/Files/fact-sheet/mdpp-beneelig-fs.pdf

Need More Information?

Visit: http://go.cms.gov/mdpp

Ask a Question: https://cmsorg.force.com/mdpp/

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

The Benefits of MDPP

Reach a population that is likely unaware of their pre-diabetes status

Empower high-risk individuals to take action by improving their health

Create community impact by promoting healthier evidence-based behaviors

Reduce risk of type 2 diabetes among Medicare beneficiaries

Achieve cost-savings through weight loss and improved population health

Footnotes

[1] https://downloads.cms.gov/files/cmmi/hcia-communityrppm-thirdannualrpt.pdf

[2] https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

[3] http://www.diabetes.org/diabetes-basics/statistics/

[4] https://www.cdc.gov/media/pressrel/2010/r101022.html

[5] James Boyle, et al., ''Projection of the Year 2050 Burden of Diabetes in the US Adult Population: Dynamic Modeling of Incidence, Mortality, and Pre-Diabetes Prevalence,'' Population Health Metrics 8, no. 29 (2010): 1–12

[6] **https://innovation.cms.gov/Files/x/mdpp-supplierreq-checklist.pdf**

[7] https://innovation.cms.gov/Files/fact-sheet/mdpp-coachelig-fs.pdf

[8] https://www.cdc.gov/diabetes/prevention/lifestyle-program/staffing-training.htm

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FAQs and Links

What is North Dakota Medicaid's Application Process?

[Process for Individual Applications] [Process for Group Applications]

I am a Sole Proprietor, Would I complete an Individual or Group Application?

It depends on how you want to enroll with ND Medicaid. Click Here for more details.

I need to bill both Institutional and Professional Fees, Do I need two enrollments?

If you are a Hospital, Rural Health Clinic, Ambulatory Surgical Center, or FQHC billing for Chiropractors/Optometrists/Podiatrists - Yes. These groups must bill Institutional fees through a Hospital record and professional fees through an Ambulatory Health Care Record (using either the taxonomy 193400000X or 193200000X).

Which Checklist should I use?

Select the checklist which matches the services you are providing. If unsure of which service applies, identify which taxonomy your group will be billing for its services (cannot be an individual's taxonomy) and choose the checklist which has that taxonomy. If you are billing services under a specific program offered by North Dakota Medicaid, you may need to use the taxonomy deisgnated for that service.

What Documents are Actually Required?

All documents listed on the application checklist are required. If a document is not required for all providers, it is noted specifically as not required next to the document name in the checklist. Additionally, all fields in all Sections on the checklist must be completed.

What is an Application Tracking Number (ATN)?

An Application Tracking Number (or "ATN" for short) is the 6 digit number assigned by the system once the online portion of the application is submitted in the Web Portal. The ATN may be assigned by the system after clicking save in the application, even before it is submitted. The ATN assigned to your application will show on the top left of each page of the online application when you click "Save" at the bottom of the screen.

What is an NPI?

Click Here to find more information about NPIs.

What is a Medicaid ID?

The North Dakota Medicaid ID is a unique identifier the system assigns to each application once it reaches the "Approved Status". It is 7 digits and replaces your Application Tracking Number. Once assigned a 7 digit Medicaid ID, please include the ID in every correspondence with the Department regarding that record.

Please Note: If you were enrolled in our old system (prior to 2013 - often called "Legacy", please do not use your previous Medicaid ID. The Legacy numbers had place holding zeros and 4-5 numbers at the end. Legacy numbers have been replaced by the new 7 digit numbers as your Medicaid ID. Use of the Legacy numbers on documents may delay your update requests.

I am a Government Agency and do not have my Federal Tax Exempt Letter. How can I obtain it?

Click Here for instructions on how to obtain a Federal Tax Exempt Letter from the IRS for Government Agencies.

Why do I need to indicate the attending practitioner for this application?

Practitioners who are on Institutional claims are required to be enrolled, but not affiliated in the system with their billing group. This information is required in order for the Department to identify which practitioner is being billed on the claims, and ensure the practitioner is either already enrolled or their application has been submitted. Additionally, if an issue arises with the practitioner's record after enrollment, the Department needs to know which billing group needs to receive communication of the issue to reach a resolution.

How do I complete the SFN 1168?

Click Here for Instructions/FAQs on the SFN 1168 (different than the instructions on pages 5 & 6 of the SFN 1168)

Why are the SSN and DOB of board members/managing employees required?

Click Here to read why SSNs and DOBs must be disclosed as part of the federal screening mandate.

Am I required to be dually enrolled with Medicare?

Click Here for a list of Group Provider Types which are required to be enrolled with Medicare in order to enroll with North Dakota Medicaid.

I am enrolled with Medicare, does the ownership information in my Medicare record need to be up to date?

Yes. Contact Medicare immediately to update the ownership in your Medicare record. If you are enrolled with Medicare, we may be unable to complete the application until the update to the Medicare record has been completed.

What is an Enrollment Effective Date?

Click Here to find more information about Enrollment Effective Dates and current back dating policies.

Am I required to use the Provider Enrollment Fax/Email Coversheet or can I use my own?

A coversheet must be submitted with all documents sent to the Department in order to identify the purpose of the documents. The Provider Enrollment Fax/Email coversheet from the Department is not required, as long as your coversheet has the following elements: 1. Provider Name; 2. NPI; 3. Medicaid ID or Application Tracking Number; 4. Name of the person in your organization who should be contacted if there are any questions about the documents submitted; 5. Phone number for the contact; 6. Email address for the contact; 7. Purpose you submitted the documents (application, revalidation, affiliation etc.). A sample list of reasons for document submission can be found on the Provider Enrollment Fax/Email Coversheet for reference.

Whose NPI and Medicaid ID goes on the SFN 615?

The NPI and Medicaid ID of the enrolling provider go on the SFN 615. As this is a revalidation for the group, do not put the Medicaid ID or NPI of an individual practitioner.

Where do I submit the Documents?

1. Standard Email – NDMedicaidEnrollment@noridian.com (please do not send EFT information, Dates of Birth (DOBs), or Social Security Numbers (SSNs) by unsecured email)

2. Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment

I have questions about the Online Application.

Click Here to find out more about the o nline Application, including an Online Application Guide and known system issues.

How to populate the taxonomy in the Online Application.

Click Here for a quick sheet guide on ho to get the taxonomy to populate in your online application.

Links:

Provider Enrollment Website

Group Provider Checklists

Provider Enrollment FAQ

Online Application Guide

How to Populate the Taxonomy in the Online Application

Enrolled Group Providers (by NPI)

Enrolled Individual Providers (by NPI)

Revision **12/16/2022**

How to Enroll an Individual

Submit a new online application. Here is a link for the online application:
https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment

Link to Online Application Guide:
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf

Within **5 business days** of submitting the online application, submit the required documents. Required documents vary depending on the provider type being enrolled (Physician, Social Worker, Counselor, etc.).

General list of required documents:

1. Medicaid Provider Application Checklist for the correct Provider Type (LACs, LAPCs, LBSWs, Physical Therapists, RNs, Targeted Case Managers, Sole Proprietors, Non-Emergent Medical Transportation, and 1915(i) providers have separate checklists. All other practitioners fill out the general individual checklist): https://www.hhs.nd.gov/human-services/medicaid/provider/medicaid-provider-enrollment-information
2. SFN 615 – Medicaid Program Provider Agreement (Must be the current version): https://www.nd.gov/eforms/Doc/sfn00615.pdf
3. License - Submit a current legible copy of the license applicable to the provider type you are enrolling as.
4. Controlled Substance Registration Certificate (DEA) – Submit a copy of your the DEA certificate (If applicable).
5. National Provider Identifier (NPI) - Submit a copy of your NPI registration. https://npiregistry.cms.hhs.gov/

You have two options to send all documents to the Department:

1. Standard Email – NDMedicaidEnrollment@noridian.com (please do not send EFT information, Dates of Birth (DOBs), or Social Security Numbers (SSNs) by unsecured email)
2. Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment

How to Enroll a Group

1. Determine what taxonomy you will be billing when submitting claims for your group. There is a separate set of taxonomies for groups. You can find a list of taxonomies that North Dakota Medicaid uses for groups at this link: https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf
    a. Once you find the taxonomy, make note of the Specialty and the Provider Type that goes with that taxonomy, you will need it to fill out the online application and checklist you will submit with your documents.
2. Use the following link to pull up the checklist for the Provider Type and Specialty you selected above: https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/group-provider-checklists-pe.pdf
    a. Review the checklist, use the links in the checklist to access the documents you do not already have.
    b. Make sure you have all the documents on the checklist (unless it says it does not apply. For example, the checklist tells you that if you are not tax exempt, you do not need to submit a tax exempt letter).
    c. Access and Review the simplified instructions for filling out the SFN 1168: https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-instructions-sfn1168.pdf
    d. Fill out all the documents and complete the checklist.
3. Fill out the online application on the "MMIS" web portal: https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment
    a. Review the Online Application Guide to help with navigating, saving, and troubleshooting sections you have questions or trouble with: https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf
    b. After the application is completed, it will bring you to a page where there is nothing for you to fill out. It will give you the one time option to print out the application. You are not required to print out the application, but if you want it for your records, this is the only time you will be able to get documentation of what you filled out.
4. Submit your documents with the checklist as a coversheet to the Department.
    a. Include with your documents the Application Number that was assigned by the system when you completed the online application:

You have two options to send all documents to the Department:

1. Standard Email: NDMedicaidEnrollment@noridian.com (please do not send EFT information, Dates of Birth (DOBs), or Social Security Numbers (SSNs) by unsecured email)
2. Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment

Sole Proprietor

Enrollments for a sole proprietor are determined by the way in which the sole proprietor wishes to bill North Dakota Medicaid - through their personal SSN or through their Employer Identification Number (EIN). *Please consult a tax professional to ensure your reporting of taxes is correct.

- If billing ND Medicaid through the sole proprietor's Social Security Number:
  - Submit an individual application.
  - The name on your 1099 will have your individual name (the legal name which matches the SSN)
- If billing ND Medicaid through the Employer Identification Number (also called EIN or FEIN) of the business:
  - Submit a group application to enroll the Tax ID as the billing provider.
  - After the group is enrolled:
    - Both the business (under the Tax ID) and the Individual (under the SSN) will need to be enrolled and affiliated to ensure claims will pay.
      - If you are already enrolled with an individual practitioner record, submit an affiliation form to "link" your individual record with your new group record.
      - If you are not yet enrolled with ND Medicaid with an individual practitioner record, submit an individual application to enroll as the "rendering" provider – Make sure to include your new group record in the Affiliations section on the Individual online application.

If a sole proprietor who enrolls under their SSN, later expands to include another provider in their business:

- Submit a group application to enroll the Tax ID of the business as the billing provider.
  - Please submit a letter along with the group application documents to advise that the business will now be the billing provider instead of the individual sole proprietor. This will allow the Department to update the sole proprietor's individual record so taxes will report under the business.
  - The new provider's services cannot be billed under the sole proprietor's SSN. In order to bill for the new provider, both the Tax ID of the business and the SSN of the new individual provider will need to be enrolled.
- After the group is enrolled
  - Submit an individual application to enroll the new provider (if they are not already enrolled).
  - If already enrolled, submit an affiliation form to "link" their individual record with the business record.

Created 2/2/2018
Revised 9/3/2019

North Dakota Department of Human Services

What is an NPI?

"The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes." – Quoted from CMS website: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html

Please visit CMS.gov to obtain more information about NPIs, or use the link above to access their NPI page.

NPIs are obtained and maintained on the "NPPES" website: https://nppes.cms.hhs.gov/#/

Created 6/8/2019
Revised 6/8/2019

North Dakota Department of Human Services

What is the CP 575/147C?

The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter providers receive from the IRS granting their Employer Identification Number (EIN). A copy of your CP 575 is required to verify the provider or supplier's legal business name and EIN. If you are not able to locate the first EIN letter, you can get a 147C letter from the IRS. This is a different type of EIN verification. See the IRS website for more information on how to obtain the letter:
https://www.irs.gov/businesses/small-businesses-self-employed/lost-or-misplaced-your-ein

Governmental Information Letter

Government entities are frequently asked to provide a tax-exempt number or “determination” letter to prove its status as a “tax-exempt” or charitable entity. For example, applications for grants from a private foundation or a charitable organization generally require this information as part of the application process. In addition, donors frequently ask for this information as substantiation that the donor’s contribution is tax deductible, and vendors ask for this to substantiate that the organization is exempt from sales or excise taxes. (Exemption from sales taxes is made under state law rather than Federal law.)

The Internal Revenue Service does not provide a tax-exempt number. A government entity may use its Federal TIN (taxpayer identification number), also referred to as an EIN (Employer Identification Number), for identification purposes.

Governmental units, such as states and their political subdivisions, are not generally subject to federal income tax. Political subdivisions of a state are entities with one or more of the sovereign powers of the state such as the power to tax. Typically they include counties or municipalities and their agencies or departments. Charitable contributions to governmental units are tax-deductible under section 170(c)(1) of the Internal Revenue Code if made for a public purpose.

An entity that is not a political subdivision but that performs an essential government function may not be subject to federal income tax, pursuant to Code section 115(1). The income of such entities is excluded from the definition of gross income as long as the income (1) is derived from a public utility or the exercise of an essential government function, and (2) accrues to a State, a political subdivision of a state, or the District of Columbia. Contributions made to entities whose income is excluded income under section 115 may be tax deductible to contributors.

In order for a government entity to receive a determination of its status as a political subdivision, instrumentality of government, or whether its revenue is exempt under Internal Revenue Code section 115, it must obtain a letter ruling by following the procedures specified in Revenue Procedure 2018-1 or its successor. There is a fee associated with obtaining a letter ruling.

Video

- Governmental Information Letter Video

As a special service to government entities, IRS will issue a "governmental information letter" free of charge. This letter describes government entity exemption from Federal income tax and cites applicable Internal Revenue Code sections pertaining to deductible contributions and income exclusion. Most organizations and individuals will accept the governmental information letter as the substantiation they need.

Government entities can request a governmental information letter by calling 1-877-829-5500.

Page Last Reviewed or Updated: 15-Aug-2018

Provider Enrollment Requirements

The Centers for Medicare and Medicaid Services (CMS) is working hard to prevent fraud, waste, and abuse in the Medicaid program and adopted regulations under the Affordable Care Act. These regulations should more effectively prevent fraudulent providers from enrolling, or continuing to participate in, Medicaid or the Children's Health Insurance Program (CHIP). The regulations require State Medicaid agencies (SMAs) to gather and verify relevant provider-submitted information. The SMAs must check specifically named databases to verify eligibility under Federal and State requirements for that provider type. SMAs will phase in using these databases to screen managed care providers by July 1, 2018.[1]

Individual providers must disclose:

- Date of birth and Social Security Number (SSN);
- Licenses and certifications;
- National Provider Identifier;
- Criminal convictions related to Federal health care programs; and
- Ownership of, and significant business transactions with, wholly owned suppliers and subcontractors.[2]

Provider entities such as corporations must disclose:

- Name and addresses of any persons with an ownership or control interest in the entity;
- Whether a person with an ownership interest is related to another person with an ownership or
- Names of other entities the owner has an ownership or control interest in; and
- Name, address, date of birth, and SSN of any managing employee.[3]

SMAs must revalidate the enrollment of all providers at least every 5 years.[4] Revalidation requires confirming the accuracy of the information disclosed during enrollment, collecting updated disclosures, and rescreening. However, the SMA may generally rely on a screening of the same provider in the same risk category by Medicare within the last 12 months or another State's Medicaid or CHIP program.[5, 6, 7]

States may establish additional or more stringent disclosure requirements for individuals or entities[8] to prevent fraudulent providers from program participation.

For More Information

CMS will provide more recent enrollment information, including information about a recent report from the Department of Health and Human Services, Office of Inspector General, in the forthcoming Provider Enrollment Toolkit. The toolkit will post to the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

To see the electronic version of this E-Bulletin and E-Bulletins on other topics posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

References

1 42 C.F.R. § 438.600(c)(2). Retrieved July 7, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=9848f1dab9b969c4c8406dcd96e7d301&mc=true&node=se42.4.438_1600&rgn=div8

2 42 C.F.R. § 438.602(b)(2). Retrieved July 7, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=9848f1dab9b969c4c8406dcd96e7d301&mc=true&node=se42.4.438_1600&rgn=div8

3 42 C.F.R. § 455.104(b)(1). Retrieved May 18, 2016, from http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0338d719892f09081c358f2778322b85&mc=true&n=pt42.4.455&r=PART&ty=HTML#sp42.4.455.b

4 Revalidation of Enrollment. 42 C.F.R. § 455.414. Retrieved June 3, 2016, from http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=048988b786a7a62635c546cae7c84c18&mc=true&n=sp42.4.455.e&r=SUBPART&ty=HTML#se42.4.455_1434

5 42 C.F.R. § 455.410(c). Retrieved June 9, 2016, from http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=d1711af7388f7b09a5cd9d7b896846b6&mc=true&n=sp42.4.455.e&r=SUBPART&ty=HTML

6 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2011, December 23). Center for Medicaid and CHIP Informational Bulletin, Medicaid/CHIP Provider Screening and Enrollment (pp.2–3). Retrieved June 10, 2016, from https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf

7 Centers for Medicare & Medicaid Services. (2016, March 21). Medicaid Provider Enrollment Compendium. (p. 35). Retrieved May 3, 2016, from https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf

8 Other State Screening Methods. 42 C.F.R. § 455.452. Retrieved May 18, 2016, from http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=048988b786a7a62635c546cae7c84c18&mc=true&n=sp42.4.455.e&r=SUBPART&ty=HTML#se42.4.455_1436

Disclaimer

This E-Bulletin was current at the time it was published or uploaded onto the web. Medicaid and Medicare policies change frequently so links to the source documents have been provided within the document for your reference.

This E-Bulletin was prepared as a service to the public and is not intended to grant rights or impose obligations. This E-Bulletin may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this material is voluntary. Inclusion of a link does not constitute CMS endorsement of the material. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

July 2016

Medicare Required
Home Health (025/082)
Hospice (025/454)
RHC (026/268)
End-Stage Renal Disease Treatment (ESRD) (026/300)
FQHC (026/361)
Swingbed (027/196)
Rehabilitation, Substance Use Disorder Unit (027/623)
Hospitals (028)
Skilled Nursing Facility (031/269)
DME (033/113 & 116 & 347)
Ambulance (034)

Revision
6/29/2019

North Dakota Department of Human Services

What is an Enrollment Effective Date?

An Enrollment Effective Date is the date your record will be made effective. Any claims submitted with a date of service prior to the enrollment effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a complete application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

North Dakota Medicaid provider enrollment staff will not process a request for provider enrollment until the Program Integrity Unit (PIU) is in receipt of all required enrollment documents, in addition to submitting the online application. Unless a retroactive enrollment effective date is requested the application effective date will be the date that staff approve the application.

This policy includes adding affiliations, adding service locations and processing taxonomy changes.

Provider specialty checklists (Individual) (Group) (NEMT) (TCM) (1915i) clearly indicate the documentation required for enrollment. It is the provider's responsibility to submit complete and accurate documents that are required for enrollment purposes.
NEMT = Non-Emergent Medical Transportation

Consideration for a retroactive enrollment effective date:

- A retroactive enrollment effective date is limited to no more than ninety (90) days prior to the date a complete application packet is received. Providers must request a retroactive enrollment effective date, when submitting the complete enrollment packet.
- Providers who have requested a retroactive effective enrollment date may submit claims for covered services provided prior to receipt of all required enrollment documents if the provider met all eligibility requirements at the time the service was provided and only if appropriate documentation of the services provided is maintained.

The PIU may consider a retro enrollment effective date that exceeds ninety days for situations involving emergent care provided to a ND Medicaid member. To request a retro enrollment effective date that exceeds ninety days, providers **must include a copy of the claim and medical records with their application documents.**

Created 6/8/2019
Revised 12/15/2022

Online Application – 1st Half of Enrollment Process

Please Note: North Dakota Medicaid provider enrollment staff will not process a request for provider enrollment until the PIU is in **receipt of all** required enrollment documents, in addition to submitting the online application.

A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a complete application packet is received by the Department. If the date requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days from the date the complete application packet was received.

**If the application is associated with an emergency service, the Department may consider a date more than 90 days prior to the date a complete application packet is received. You must include a copy of the claim and medical records with your application documents.*

For More complete coverage of the Online Application screens, please use this link to access the Online Application Guide: https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf

Link to Online Application: https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment

How to Populate the Taxonomy

Make sure all the fields on the License page are closed.

1. Select the Provider Type that corresponds with your taxonomy (do not know which type to choose, see the links below)
2. Click "Add License"
   a. Add in the license information
   b. Click the small save to the right of the License field.
3. Click "Add Specialty"
   a. Choose the Specialty that corresponds with your taxonomy (do not know which type to choose, see the links below)
   b. The certification # is "00000"
   c. Begin date is the date you are requesting your enrollment to be effective
   d. End date is 12/31/9999
   e. Board is "Other"
   f. Click the small save to the right of the Specialty field
4. Click the save on the bottom of the page
5. Click "Add Taxonomy"
   a. The taxonomy you need should be available in the drop down box
   b. Begin date is the date you are requesting your enrollment to be effective
   c. End date is 12/31/9999
   d. Click the small save to the right of the Taxonomy field
6. Click the save on the bottom of the page.

Will Not Allow the Letter "W" to be Typed

This is a known browser compatibility issue. Workaround: Open Word, type the letter "W", Copy, Paste wherever needed.

End Date Required, But Information is Still Current

Use 12/31/9999

Specialty Requires Certification Number, But There is No Board Certification for this Specialty

Use "00000"

North Dakota Department of Human Services

How To: Select a Taxonomy in the Online Application

Make sure all the fields on the License page are closed.

1. Select the Provider Type that corresponds with your taxonomy (do not know which type to choose, see the links below)
2. Click “Add License”
    a. Add in the license information
    b. Click the small save to the right of the License field.
3. Click “Add Specialty”
    a. Choose the Specialty that corresponds with your taxonomy (do not know which type to choose, see the links below)
    b. The certification # is “00000”
    c. Begin date is the date you are requesting your enrollment to be effective
    d. End date is 12/31/9999
    e. Board is “Other”
    f. Click the small save to the right of the Specialty field
4. Click the save on the bottom of the page
5. Click “Add Taxonomy”
    a. The taxonomy you need should be available in the drop down box
    b. Begin date is the date you are requesting your enrollment to be effective
    c. End date is 12/31/9999
    d. Click the small save to the right of the Taxonomy field
6. Click the save on the bottom of the page.

Link to Provider Type/Specialty/Taxonomy List for Individual Applications:
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf

Link to Provider Type/Specialty/Taxonomy List for Group Applications:
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf