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# Medicaid Provider Enrollment

## Individual Provider Enrollment

### Individual Provider Introduction

### Procedure

Access ND MMIS Web Portal:

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

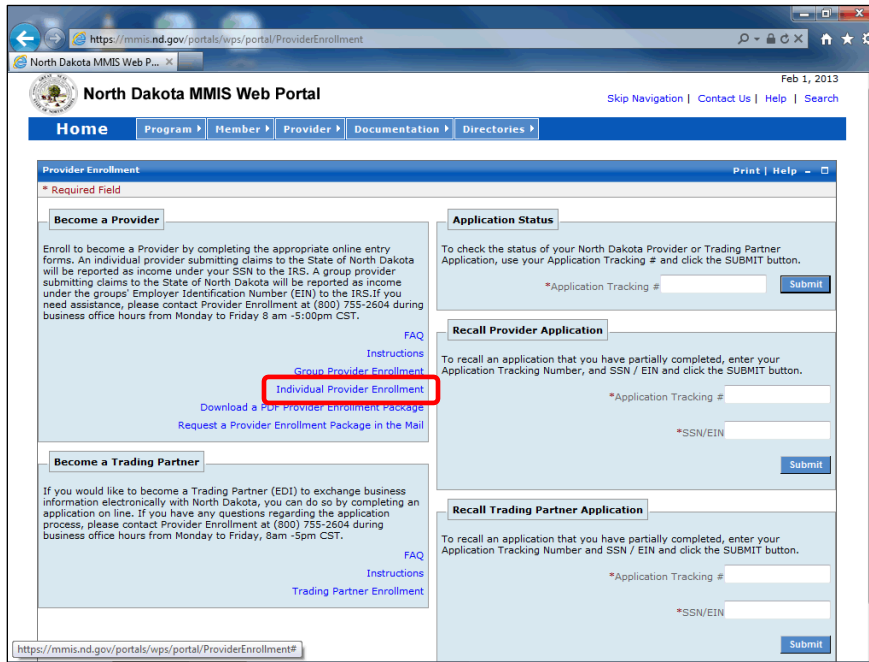


North Dakota MMIS Web Portal

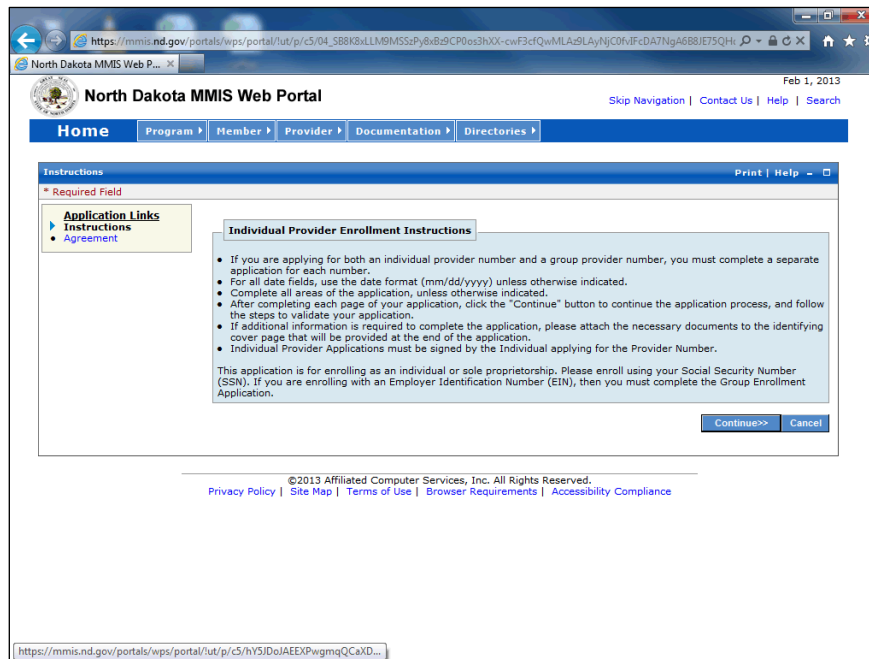
MAR 25, 2014

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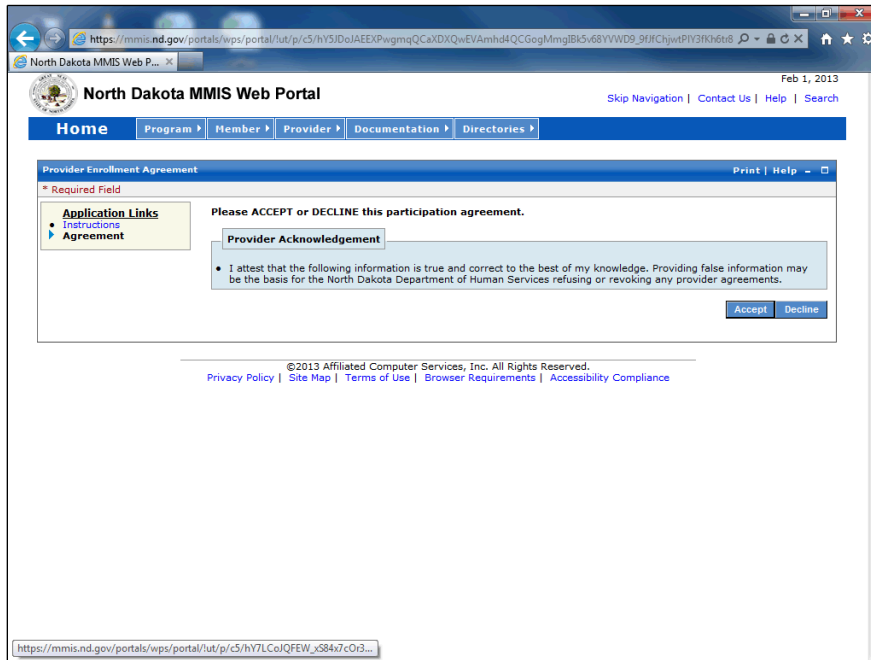
<b>Home</b>   <a href="#">Program</a>   <a href="#">Member</a>   <a href="#">Provider</a>   <a href="#">Documentation</a>   <a href="#">Directories</a>	
Provider Enrollment <span style="float: right;">Print   Help</span>	
* Required Field	
<b>Become a Provider</b> Enroll to become a Provider by completing the appropriate online entry forms. An individual provider submitting claims to the State of North Dakota will be reported as income under your SSN to the IRS. A group provider submitting claims to the State of North Dakota will be reported as income under the groups' Employer Identification Number (EIN) to the IRS. If you need assistance, please contact Provider Enrollment at (800) 755-2604 during business office hours from Monday to Friday 8 am -5:00pm CST. <a href="#">FAQ</a> <a href="#">Instructions</a> <a href="#">Group Provider Enrollment</a> <a href="#">Individual Provider Enrollment</a> <a href="#">Download a PDF Provider Enrollment Package</a> <a href="#">Request a Provider Enrollment Package in the Mail</a>	<b>Application Status</b> To check the status of your North Dakota Provider or Trading Partner Application, use your Application Tracking # and click the SUBMIT button. *Application Tracking # <input type="text"/> <input type="button" value="Submit"/>
<b>Become a Trading Partner</b> If you would like to become a Trading Partner (EDI) to exchange business information electronically with North Dakota, you can do so by completing an application on line. If you have any questions regarding the application process, please contact Provider Enrollment at (800) 755-2604 during business office hours from Monday to Friday, 8am -5pm CST. <a href="#">FAQ</a> <a href="#">Instructions</a> <a href="#">Trading Partner Enrollment</a>	<b>Recall Provider Application</b> To recall an application that you have partially completed, enter your Application Tracking Number, and SSN / EIN and click the SUBMIT button. *Application Tracking # <input type="text"/> *SSN/EIN <input type="text"/> <input type="button" value="Submit"/>
	<b>Recall Trading Partner Application</b> To recall an application that you have partially completed, enter your Application Tracking Number and SSN / EIN and click the SUBMIT button. *Application Tracking # <input type="text"/> *SSN/EIN <input type="text"/> <input type="button" value="Submit"/>




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



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



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

# Identifying Information Procedure

**Identifying Information - Section 1**

\*Last Name \*First Name MI Suffix Title

\*Date of Birth

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

\*SSN

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

**Current/Previous ND Provider #**  
 ? Please enter your current and/or previous ND Provider numbers. [Add Previous Provider ID](#)

**Previous ND Provider IDs**  
 ND Provider ID #

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

**Help**

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

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

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

**Current/Previous ND Provider # :**  
 To enter your Current and/or Previous ND Provider #, click the 'Add Previous ND Provider #' button. Enter the

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

Identifying Information - Section 1

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

\*Date of Birth: 12/15/1960

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

\*SSN: 505-55-5555

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

**Current/Previous ND Provider #**

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

**Previous ND Provider IDs**

ND Provider ID #

**Previous Names**

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

**Add Previous Provider ID** (highlighted in red)

**Previous ND Provider IDs**

ND Provider ID #

**Add Previous ND Provider IDs** (highlighted in red)

Save | Reset | Cancel

ND Provider ID #

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

your IRS form w9.

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

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

**Current/Previous ND Provider #:**  
To enter your Current and/or Previous ND Provider #, click the 'Add Previous ND Provider #' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row

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

Click the **Save** button at the bottom of the page to validate the page content and save the information. Click the **Continue** button to move onto to the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

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

System successfully saved the Information.

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

ND Provider ID #
000012345

1 - 1 of 1

**Previous Names**

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

Yes  No

Continue>> Reset **Save** Exit Application

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

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

**Application Links**

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

**Identifying Information- Section 1**

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

\*Date of Birth: 12/15/1960

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

\*SSN: 505555555

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

**Current/Previous ND Provider #**

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

**Previous ND Provider IDs**

ND Provider ID #: 000012345

1 - 1 of 1

**Previous Names**

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

\*Date of Birth: 12/15/1960

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

\*SSN: 505555555

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

**Current/Previous ND Provider #**

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

**Previous ND Provider IDs**


ND Provider ID #: 000012345

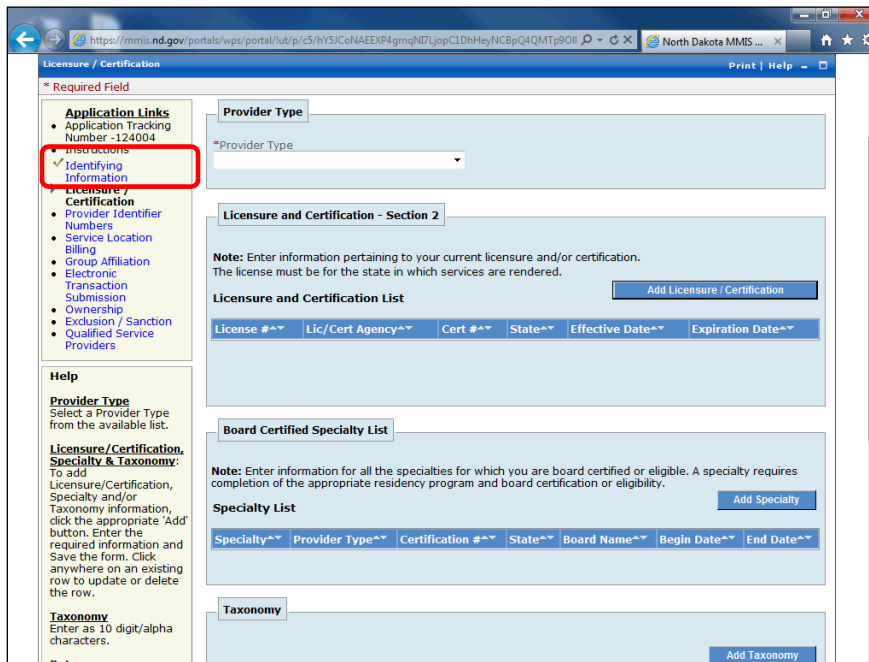
1 - 1 of 1

**Previous Names**

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

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

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



The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/!ut/p/c5/hy3jC6NAEXp4gmqN7LjopCLDhHeyNCBpQ4QMTp90I>. The page title is "Licensure / Certification".

**Required Field**

- Application Links
  - Application Tracking Number -124004
  - Instructions
  - Identifying Information** (highlighted with a red box)
  - Licensure / Certification
    - Provider Identifier Numbers
    - Service Location Billing
    - Group Affiliation
    - Electronic Transaction Submission
    - Ownership
    - Exclusion / Sanction
    - Qualified Service Providers

**Help**

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

**Licensure / Certification, Specialty & Taxonomy:**  
To add Licensure/Certification, Specialty and/or Taxonomy information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

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

**Provider Type**  
\*Provider Type

**Licensure and Certification - Section 2**  
Note: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered.  
Add Licensure / Certification

**Licensure and Certification List**

License #^^	Lic/Cert Agency^^	Cert #^^	State^^	Effective Date^^	Expiration Date^^

**Board Certified Specialty List**  
Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility.  
Add Specialty

**Specialty List**

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

**Taxonomy**  
Add Taxonomy

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

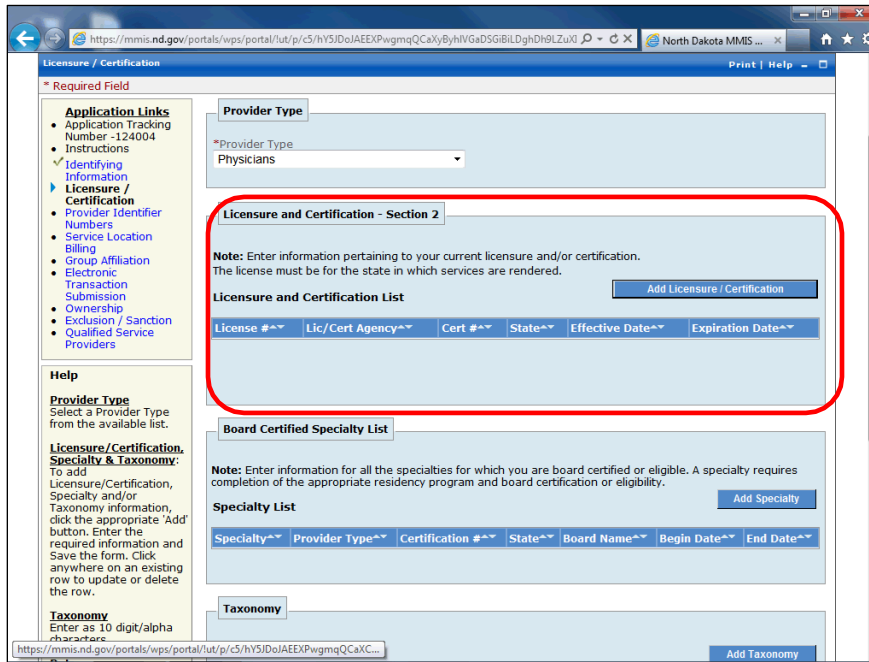
# Licensure/Certification

## Procedure

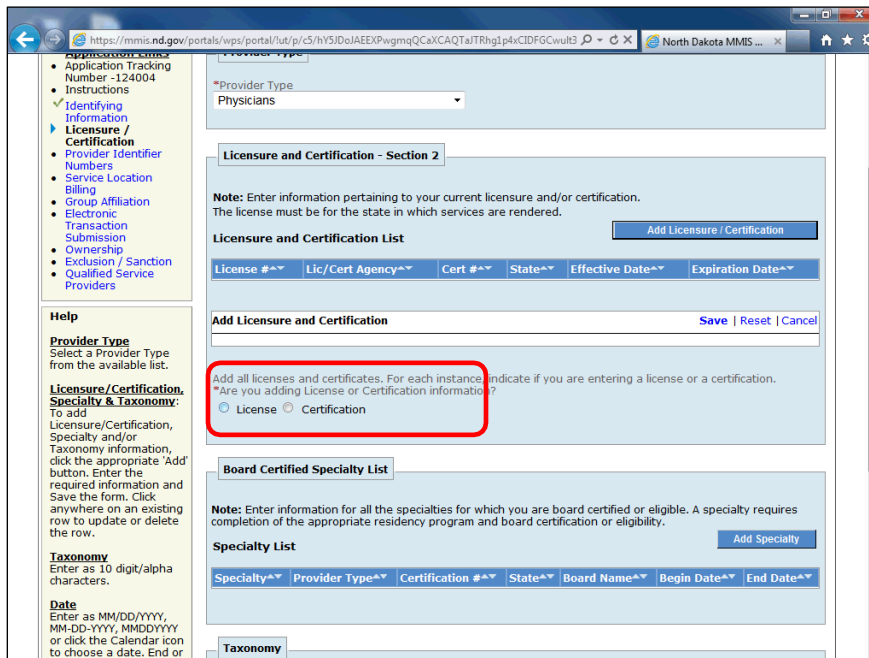
**Provider Type:** Reference this site for the list of acceptable individual provider type, specialty, and taxonomy codes: <https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-individual-provider-code-taxonomy.pdf>

The screenshot shows the North Dakota MMIS Web Portal interface. The main content area is titled "Licensure / Certification" and contains a form with several sections. The "Provider Type" dropdown menu is highlighted with a red box. Below it, there is a "Licensure and Certification - Section 2" section with a note and an "Add Licensure / Certification" button. Further down, there is a "Board Certified Specialty List" section with a note and an "Add Specialty" button. The left sidebar contains "Application Links" and "Help" sections.

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

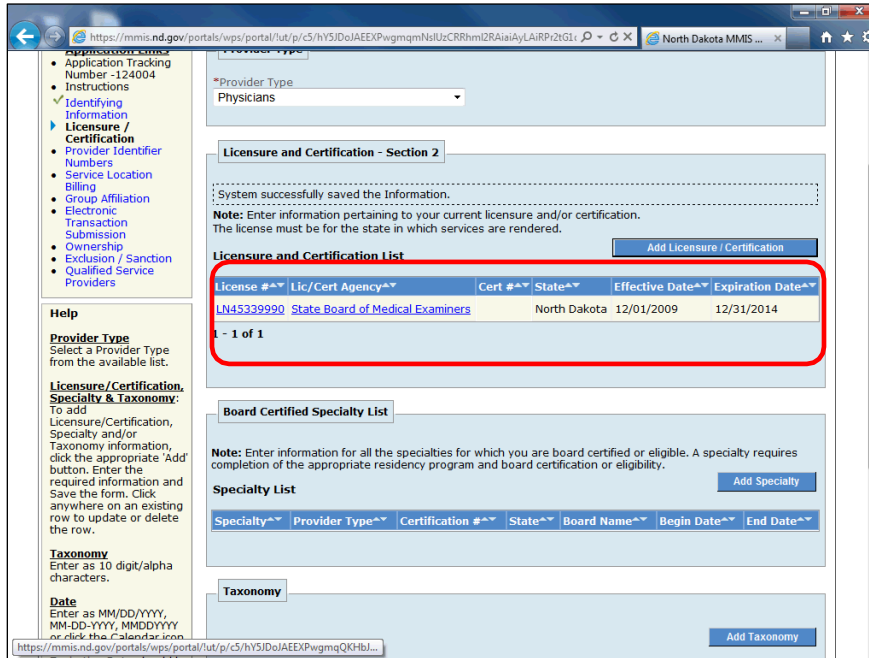


Step	Action
3.	<b>Section 2 – License is required.</b>
Step	Action
4.	Click the <b>Add Licensure / Certification</b> button.

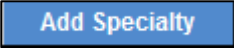


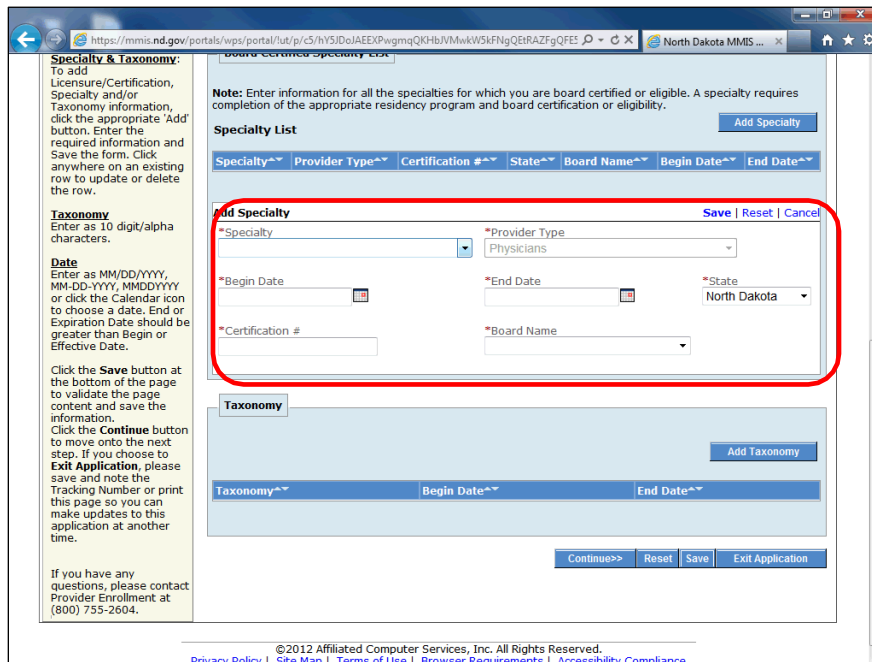
Step	Action
5.	Click the <b>License or Certification</b> option.

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



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

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




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

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

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

The screenshot shows a web browser window with the URL [https://mmis.nd.gov/portals/wps/portal/tut/p/c5/hy7LDolwEW\\_HS-YAQXqst...](https://mmis.nd.gov/portals/wps/portal/tut/p/c5/hy7LDolwEW_HS-YAQXqst...). The page title is "North Dakota MMIS". The main content area is titled "Specialty & Taxonomy" and contains the following elements:

- Specialty & Taxonomy:** A section with instructions on how to add licensure/certification, specialty, and/or taxonomy information. It includes a "Note" stating that a specialty requires completion of the appropriate residency program and board certification or eligibility.
- Specialty List:** A table with columns: Specialty, Provider Type, Certification #, State, Board Name, Begin Date, and End Date. The table contains one entry: Internal Medicine, Physicians, CN88988589, North Dakota, AmbD Internal Medicine, 12/01/2009, 12/31/2014.
- Taxonomy:** A section with an "Add Taxonomy" button highlighted by a red box. Below it is a table with columns: Taxonomy, Begin Date, and End Date.
- Buttons:** "Add Specialty", "Add Taxonomy", "Continue>>", "Reset", "Save", and "Exit Application".

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

**Specialty & Taxonomy:**  
To add Licensure/Certification, Specialty and/or Taxonomy information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

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

**Date**  
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.

Click the **Save** button at the bottom of the page to validate the page content and save the information.  
Click the **Continue** button to move onto the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

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

**Note:** Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility.

**Specialty List** [Add Specialty](#)

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

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

Taxonomy^v Begin Date^v End Date^v

**Add Taxonomy** [Save](#) | [Reset](#) | [Cancel](#)

\*Taxonomy (10 digits/alphas)

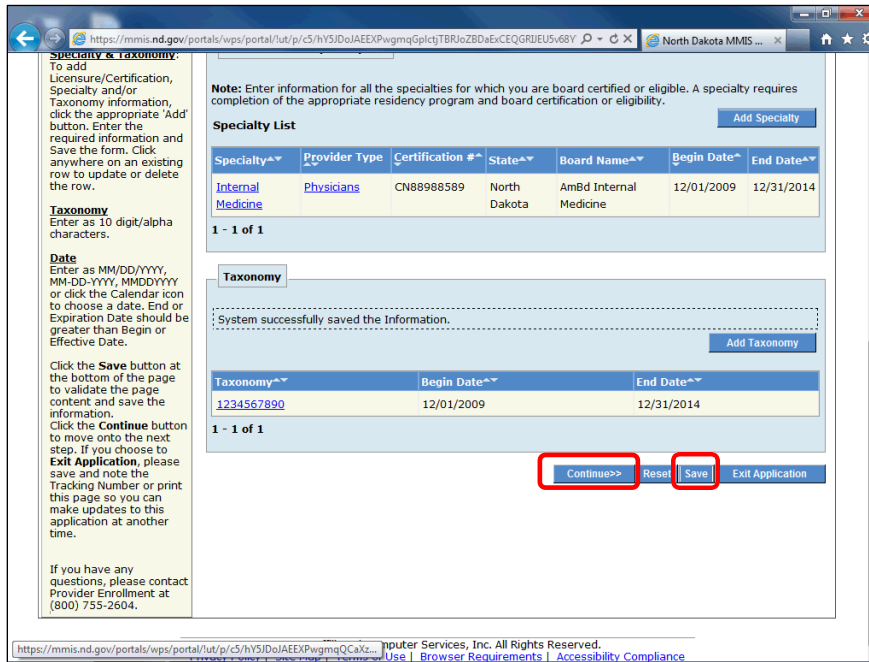
\*Begin Date


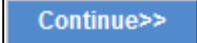
End Date

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

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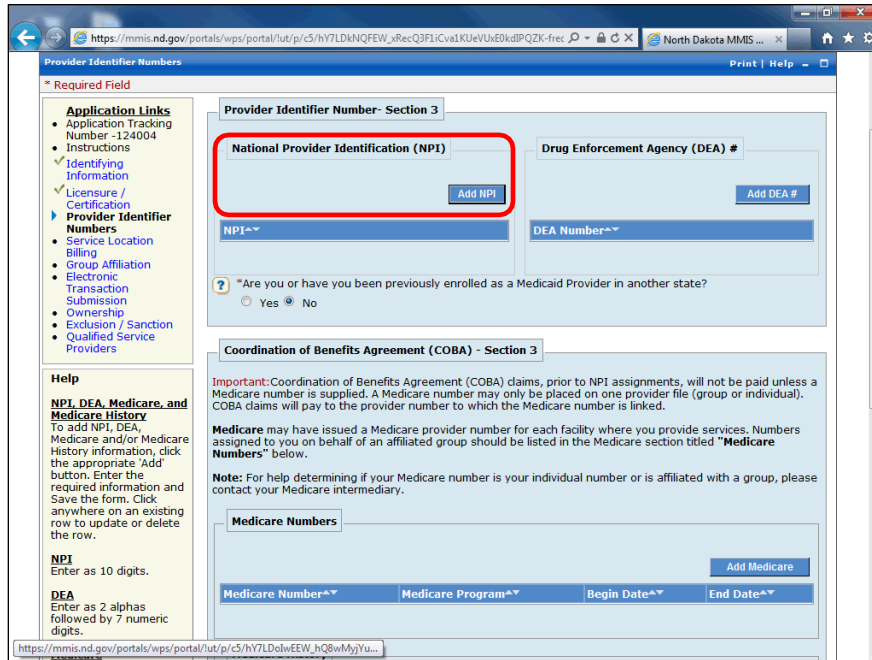
Step	Action
23.	Enter the desired information into the <b>Taxonomy (10 digits/alphas)</b> field.
Step	Action
24.	Enter the <b>Begin Date</b> .
Step	Action
25.	Enter the <b>End Date</b> . Enter 12/31/9999.
Step	Action
26.	Click the <b>Save</b> link. <a href="#">Save</a>



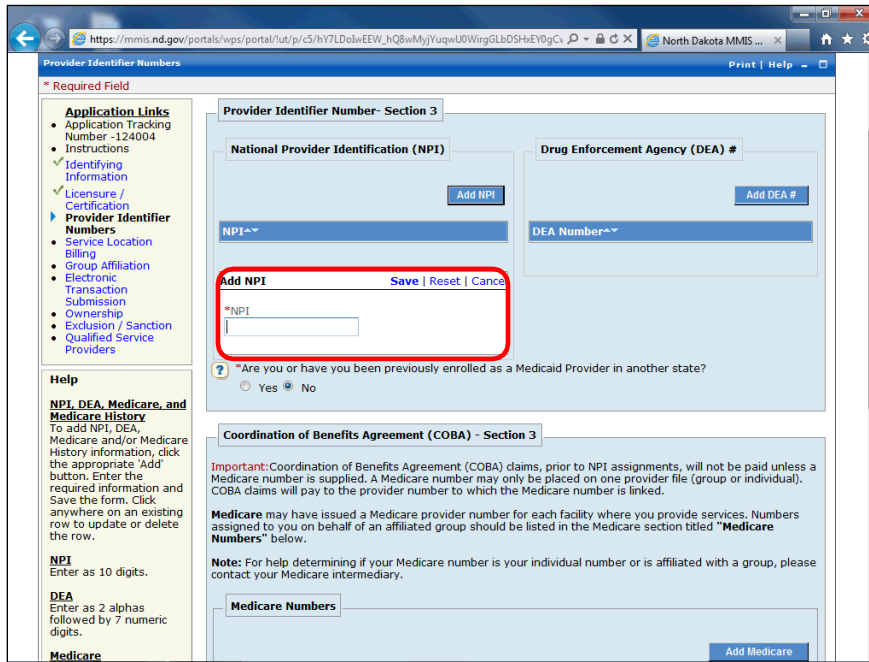
Step	Action
27.	Click the <b>Save</b> button. 
Step	Action
28.	Click the <b>Continue&gt;&gt;</b> button. 
Step	Action
29.	The next section will take you through how to complete the Provider Identifier Numbers page. <b>End of Procedure.</b>

# Provider Identifier Numbers

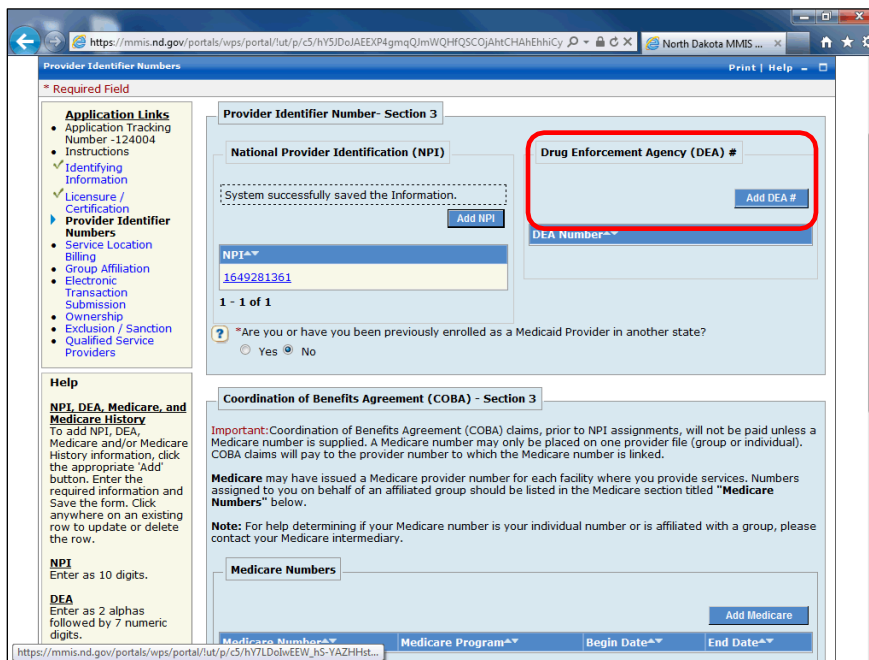
## Procedure




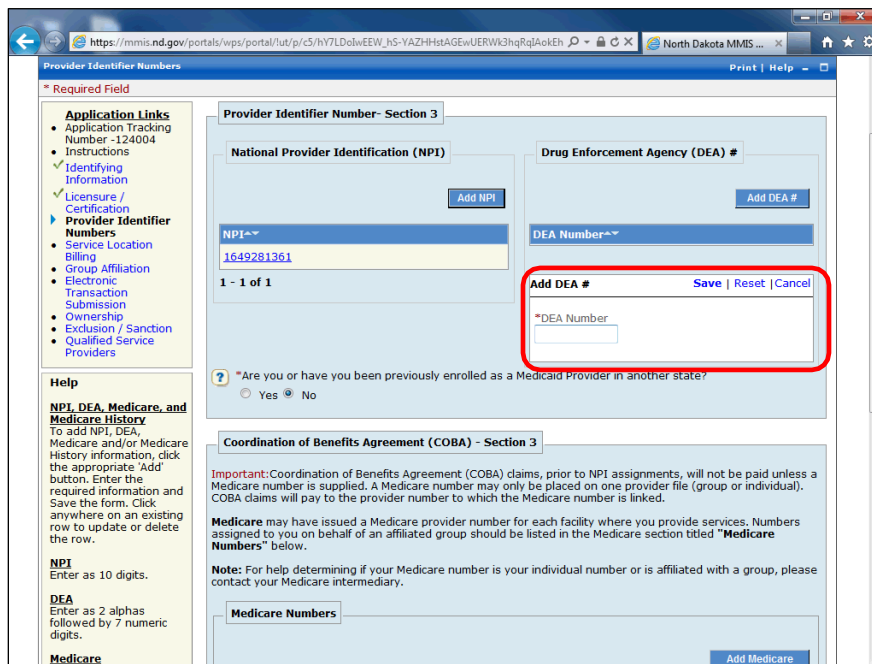
Step	Action
1.	<p>Click the <b>Add NPI</b> button.</p> <p><b>Add NPI</b></p> <p><b>*Required for all providers except Atypical (QSP, Transportation, Meals, and Lodging) providers.</b></p>




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



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



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

**Provider Identifier Numbers**

**Required Field**

**Application Links**

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

**Help**

**NPI, DEA, Medicare, and Medicare History**  
To add NPI, DEA, Medicare and/or Medicare History information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**NPI**  
Enter as 10 digits.

**DEA**  
Enter as 2 alphas followed by 7 numeric digits.

**Medicare**

**Provider Identifier Number- Section 3**

**National Provider Identification (NPI)**

Add NPI

NPI

1649281361

1 - 1 of 1

**Drug Enforcement Agency (DEA) #**

Add DEA #

System successfully saved the Information.

DEA Number

DE1234567

1 - 1 of 1

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

Yes  No

Other Medicaid State

**Coordination of Benefits Agreement (COBA) - Section 3**

**Important:** Coordination of Benefits Agreement (COBA) claims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA claims will pay to the provider number to which the Medicare number is linked.

**Medicare** may have issued a Medicare provider number for each facility where you provide services. Numbers assigned to you on behalf of an affiliated group should be listed in the Medicare section titled **"Medicare Numbers"** below.

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

**Medicare Numbers**

Add Medicare

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

**NPI, DEA, Medicare, and Medicare History**  
To add NPI, DEA, Medicare and/or Medicare History information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.

**NPI**  
Enter as 10 digits.

**DEA**  
Enter as 2 alphas followed by 7 numeric digits.

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

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

**Date**  
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.

Click the **Save** button at the bottom of the page to validate the page content and save the information. Click the **Continue** button to move onto to the next step. If you choose to **Exit Application**, please save

**Coordination of Benefits Agreement (COBA) - Section 3**

**Important:** Coordination of Benefits Agreement (COBA) claims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA claims will pay to the provider number to which the Medicare number is linked.

**Medicare** may have issued a Medicare provider number for each facility where you provide services. Numbers assigned to you on behalf of an affiliated group should be listed in the Medicare section titled "**Medicare Numbers**" below.

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

**Medicare Numbers**

[Add Medicare](#)

Medicare Number	Medicare Program	Begin Date	End Date
<a href="#">Add Medicare #</a> <a href="#">Save</a>   <a href="#">Reset</a>   <a href="#">Cancel</a>			
*Medicare Number	*Begin Date	*End Date	

\*Please check all that apply:



All  Medicare Program A  Medicare Program B  Medicare Program C  Medicare Program D

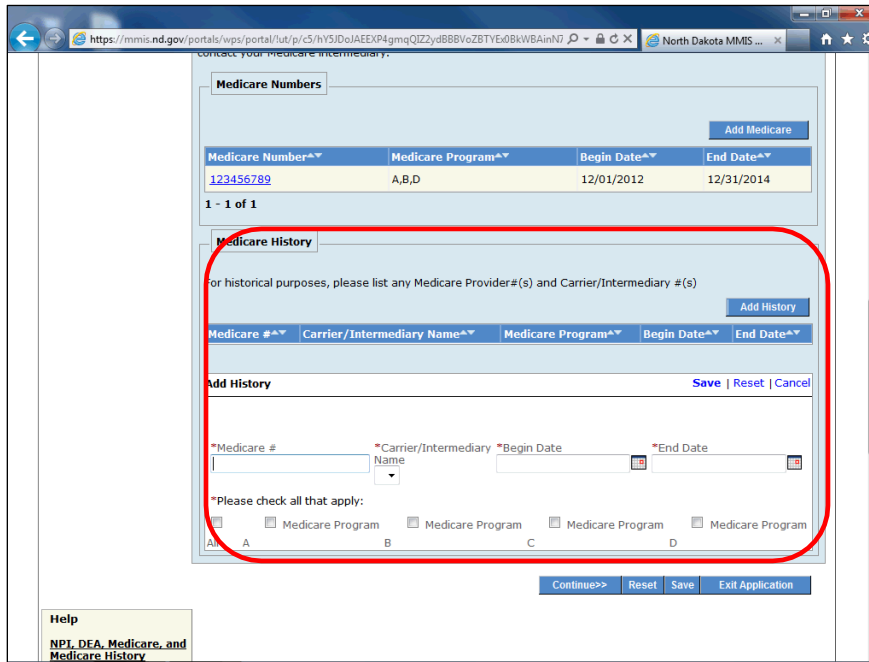
**Medicare History**

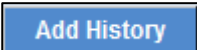


For historical purposes, please list any Medicare Provider #(s) and Carrier/Intermediary #(s)

[Add History](#)

Medicare #	Carrier/Intermediary Name	Medicare Program	Begin Date	End Date
------------	---------------------------	------------------	------------	----------

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



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

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

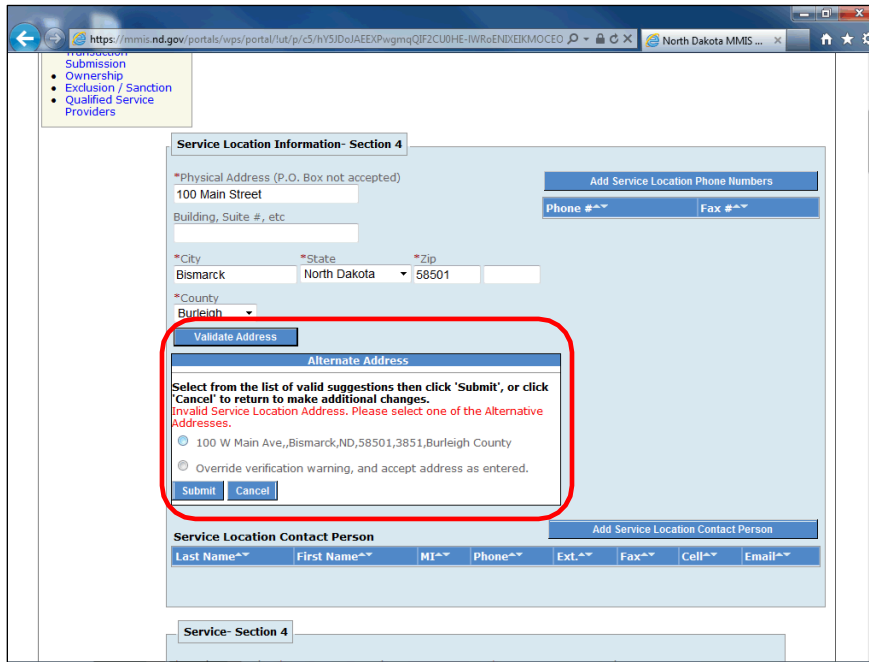
## Service Location Billing Procedure

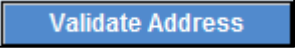

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/utl/pi/c5/nv5JDJAEEXPwgmqQCaXLXQw5rcCqsCGkDgEwhQIRI>. The page title is "North Dakota MMIS". The main content area is titled "Service Location Information- Section 4". It contains several sections:

- Physical Address (P.O. Box not accepted)**: A text input field.
- Building, Suite #, etc**: A text input field.
- \*City**: A text input field.
- \*State**: A dropdown menu currently showing "North Dakota".
- \*Zip**: A text input field.
- \*County**: A dropdown menu.
- Validate Address**: A blue button.
- Service Location Contact Person**: A section with a blue button "Add Service Location Contact Person" and several dropdown menus for "Last Name", "First Name", "MI", "Phone", "Ext.", "Fax", "Cell", and "Email".
- Service- Section 4**: A section with radio buttons for "Gender Served" (Male, Female, Both), "Age Range Served" (All, 0-5 Years, 6-12 Years, 13-17 Years, 18-21 Years, 22-59 Years, 60+ Years), and "Languages Supported" (Available: Albanian, American Sign Language, Arabic, Bangla; Selected: English). There is also an "Other Language:" text input field.

A red circle highlights the "Physical Address" field and the "City", "State", and "Zip" fields.

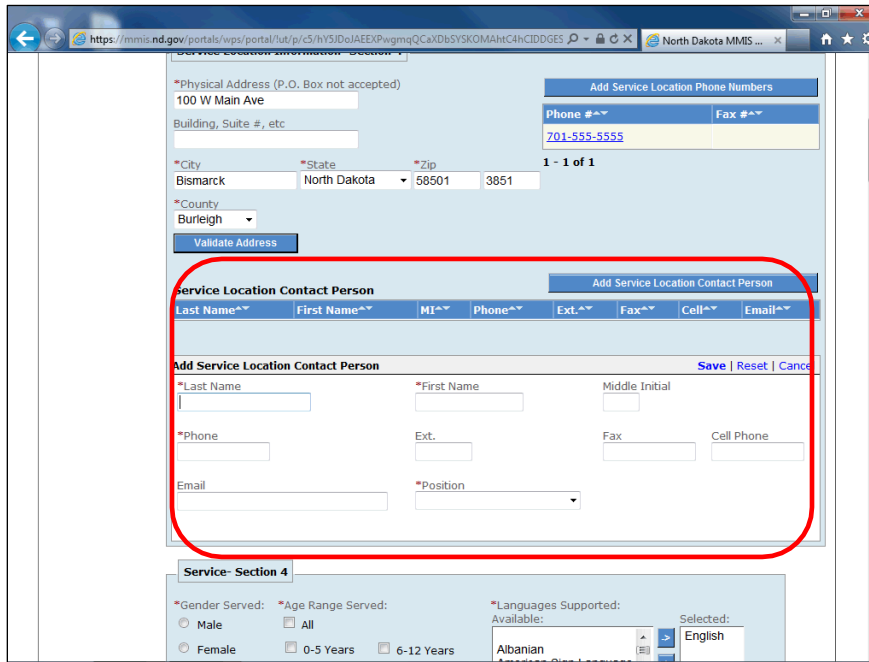
Step	Action
1.	Enter the desired information into the <b>Physical Address (P.O. Box not accepted)</b> field.
Step	Action
2.	Enter the desired information into the <b>City</b> field.
Step	Action
3.	Enter the desired information into the <b>Zip</b> field.
Step	Action
4.	Click the <b>County</b> list and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





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

The screenshot shows a web form titled "Service Location Information" with a "Service Location Phone Numbers" section highlighted in red. The form includes fields for physical address (100 W Main Ave), city (Bismarck), state (North Dakota), zip (58501), and county (Burleigh). Below these are fields for "Service Location Contact Person" (Last Name, First Name, MI, Phone, Ext., Fax, Cell, Email). The highlighted section contains "Add Service Location Phone Numbers" buttons, "Phone #", and "Fax #" input fields, and a "Save" button. Below the highlighted section is a "Service- Section 4" with options for gender served, age range served, languages supported, and service area definition.

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



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

**Service- Section 4**

\*Gender Served:  Male  Female  Both

\*Age Range Served:  All  0-5 Years  6-12 Years  13-17 Years  18-21 Years  22-59 Years  60+ Years

\*Languages Supported: Available: Albanian, American Sign Language, Arabic, Bangla. Selected: English

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

? \*Is this location Wheelchair accessible?  Yes  No

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

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

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

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

Hours Of Operation: \_\_\_\_\_ Interpretive Services Available: \_\_\_\_\_

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

**Service- Section 4**

\*Gender Served:  Male  Female  Both

\*Age Range Served:  All  0-5 Years  6-12 Years  13-17 Years  18-21 Years  22-59 Years  60+ Years

\*Languages Supported: Available: Albanian, American Sign Language, Arabic, Bangla. Selected: English

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

? \*Is this location Wheelchair accessible?  Yes  No

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

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

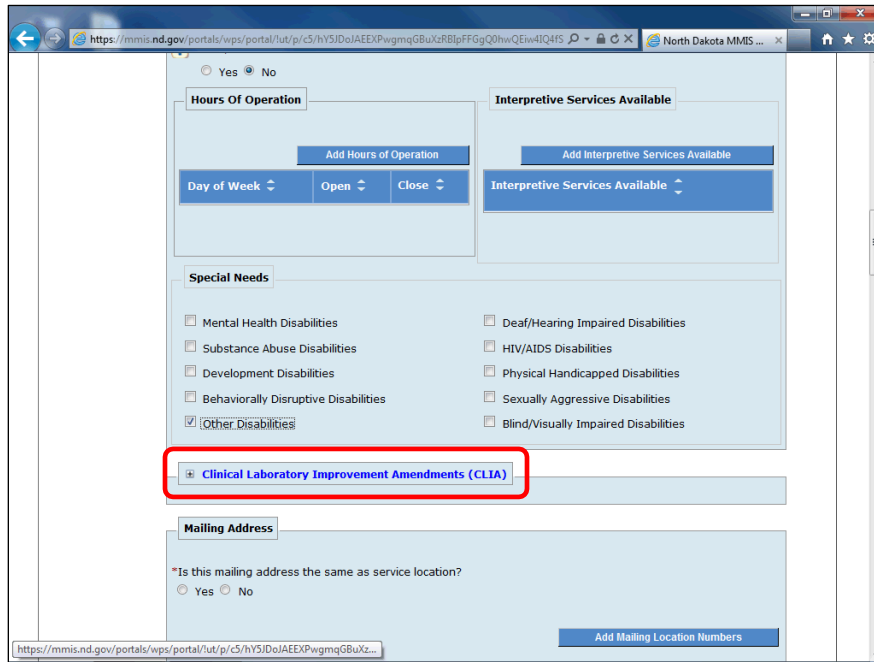
? \*Do you wish to be excluded from public provider searches?  Yes  No

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

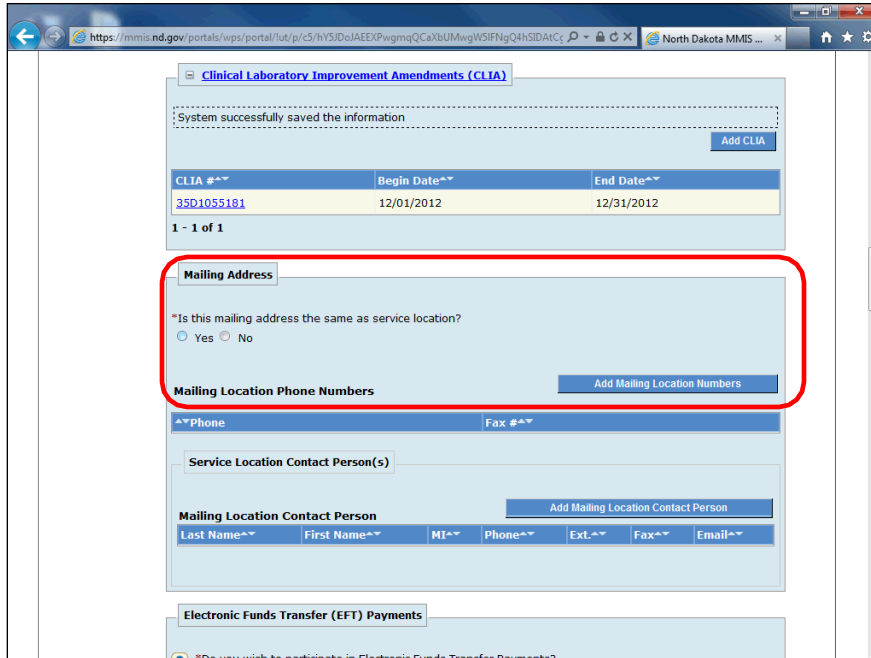
Hours Of Operation: \_\_\_\_\_ Interpretive Services Available: \_\_\_\_\_

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

The screenshot displays a web form with several sections. A red oval highlights the 'Hours Of Operation' and 'Interpretive Services Available' sections. Below this, the 'Special Needs' section contains a grid of checkboxes for various disabilities. Further down are sections for 'Clinical Laboratory Improvement Amendments (CLIA)', 'Mailing Address' (with a question about whether the mailing address is the same as the service location), and 'Mailing Location Phone Numbers'.



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



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

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

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

The screenshot shows a web browser window with the URL [https://mmis.nd.gov/portals/wps/portal/luk/p/c5/nY7LDolwEEW\\_h5-YQXkua2kwkVbLS2BD5FCjCgCoPT](https://mmis.nd.gov/portals/wps/portal/luk/p/c5/nY7LDolwEEW_h5-YQXkua2kwkVbLS2BD5FCjCgCoPT). The page displays a form for entering banking and billing information. The 'Billing Address' section is highlighted with a red rounded rectangle. It contains the following elements:

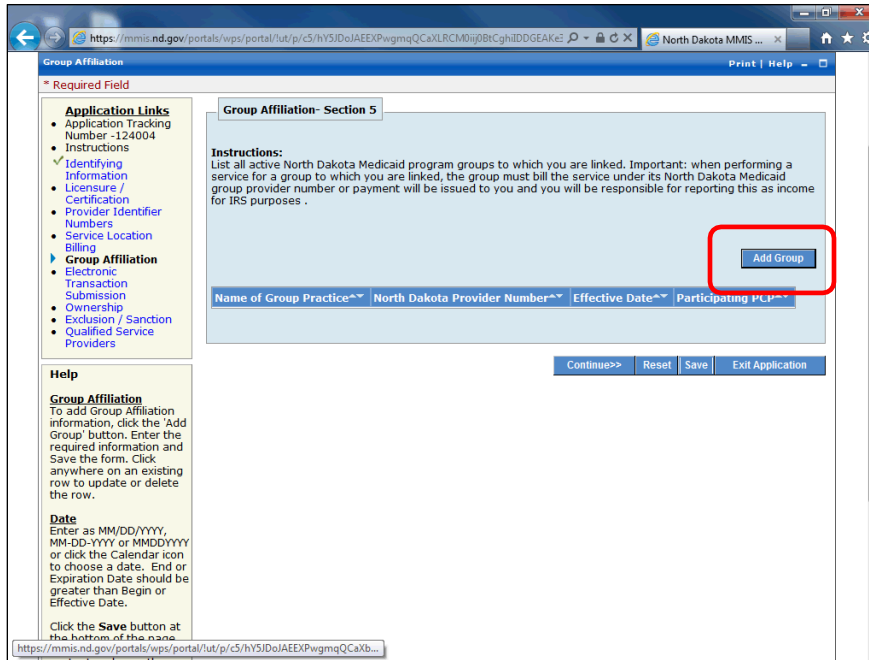
- Banking Information:**
  - \*Bank Routing Transit Number: 291378130
  - \*Bank Account Number: 000000000
  - \*Account Type: CHECKING ACCT
  - \*Bank Phone #: 701-555-5555
  - \*Account Holder Name: Smith
  - \*Payee Provider's Name: Smith
- Billing Address Section (highlighted):**
  - Note: The billing address is equivalent to your Pay To address where your checks will be mailed. \*Is this billing address the same as the service location?
  - Radio buttons for Yes and No.
  - Section: **Billing Location Phone Numbers** with an 'Add Billing Location Numbers' button.
  - Fields: Phone # and Fax #.
  - Section: **Billing Location Contact Person(s)** with an 'Add Billing Location Contact Person' button.
  - Fields: Last Name, First Name, Middle Initial, Phone, Ext., Fax, Position, Email.
- Remittance Advice Section:**
  - \*Requested Delivery Media for Remittance Advices(RAs)
  - Radio buttons for Electronic (835), Web Portal Inbox, and Paper.
  - Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed.


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



The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/tut/p/c5/ny5JDoJAEEpvgmqQZZiQ1Ito3M04YQUQORYUFQQL>. The page is titled "North Dakota MMIS ...". It contains several sections: "Billing Location Phone Numbers" with a table for phone and fax numbers; "Billing Location Contact Person(s)" with a table for contact information; "Remittance Advice" (highlighted with a red box) with radio buttons for "Electronic (835)", "Web Portal Inbox", and "Paper", and a note: "Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed."; and "Other Details" with dropdown menus for "Print Suspend", "RA Sort Ind", and "Bulletin Media". At the bottom are buttons for "Continue>>", "Reset", "Save", and "Exit Application". A "Help" section at the bottom left says "Service Location: Enter the physical address of your primary".

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

# Group Affiliation Procedure



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

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

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

## Electronic Transaction Submission

### Procedure

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

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

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

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

The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/ut/p/c5/1Y5JDoJAEEXpWgFMFqjxm0IRgFfNqQEIEHMiw6RPh0t>. The page is titled "Electronic Transaction Submission" and is in "Section 6".

**Required Field**

**Application Links**

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

**Help**

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

Click the **Save** button at the bottom of the page to validate the page content and save the information.  
Click the **Continue** button to move onto the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print

**Electronic Transaction Submission- Section 6**


Providers who choose to submit claims, must be aware that payment of claims will be from Federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Further, Providers must understand and agree to do the following:

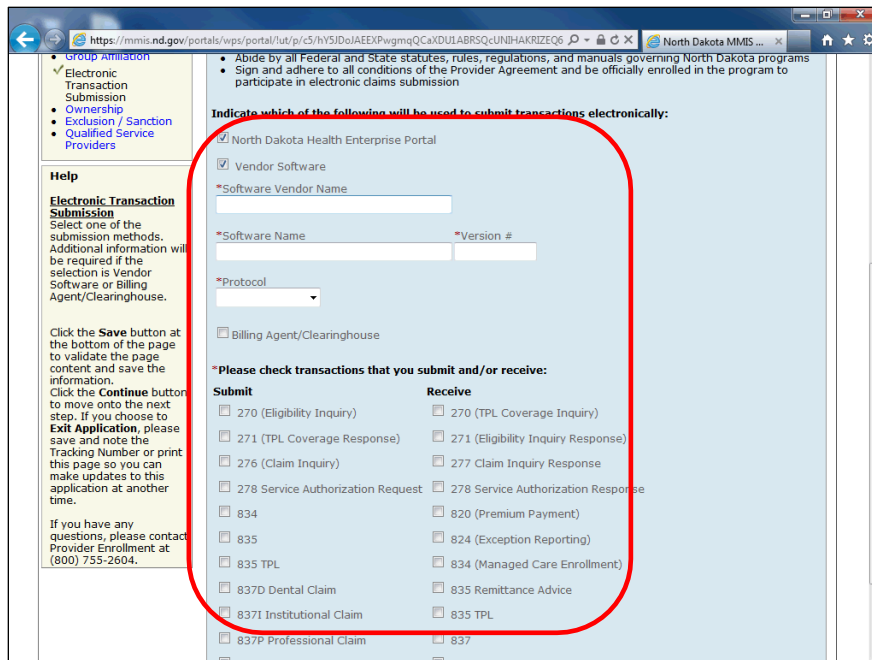
- Safeguard against abuse in the use of electronic claims submission
- Correctly enter the claims data, monitor the data, and certify that the data entered is correct
- Assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments which might result from carelessness or fraud
- Have on file the applicable documentation to substantiate any claims submitted
- Allow the agency or any of its designees and representatives to review and copy all records, including source documents and data related to information entered through electronic claims submission
- Abide by all Federal and State statutes, rules, regulations, and manuals governing North Dakota programs
- Sign and adhere to all conditions of the Provider Agreement and be officially enrolled in the program to participate in electronic claims submission

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

- North Dakota Health Enterprise Portal
- Vendor Software
- Billing Agent/Clearinghouse


Buttons: Continue>> Reset Save Exit Application

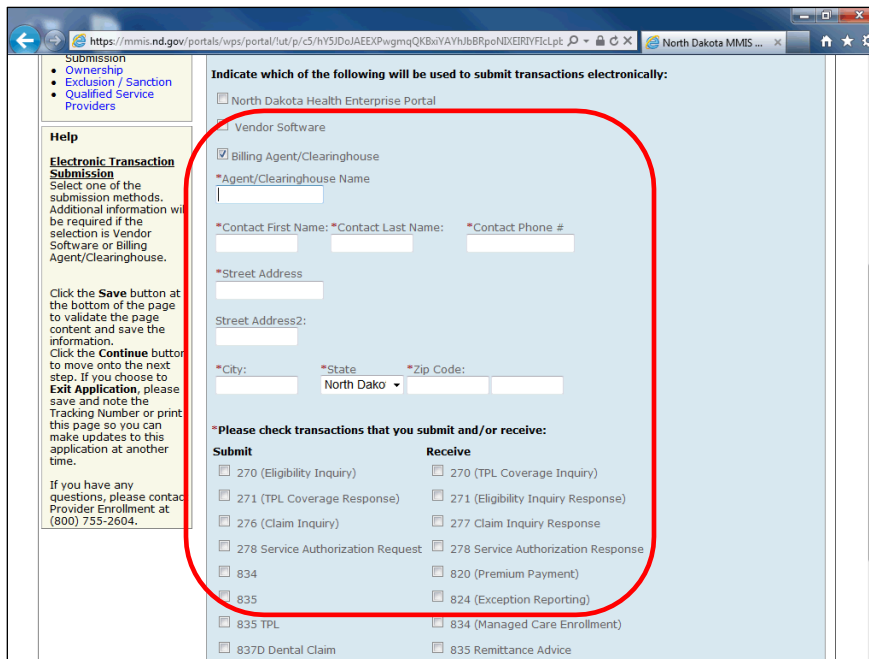
Step	Action
1.	<b>If using ND MMIS Web Portal, claims can be entered directly into the ND MMIS Web Portal.</b>
Step	Action
2.	Click the <b>ND MMIS Web Portal</b> option. <b>Select this option if the individual is a rendering provider billing under a group.</b>
Step	Action
3.	Click the <b>Save</b> button. 



The screenshot shows the 'Electronic Transaction Submission' page. On the left, there is a 'Help' section with instructions: 'Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button to move onto the next step. If you choose to Exit Application, please save and note the Tracking Number or print this page so you can make updates to this application at another time. If you have any questions, please contact Provider Enrollment at (800) 755-2604.' The main content area is titled 'Indicate which of the following will be used to submit transactions electronically:'. It has a checked box for 'North Dakota Health Enterprise Portal' and a checked box for 'Vendor Software'. Below this, there are fields for '\*Software Vendor Name', '\*Software Name', '\*Version #', and '\*Protocol'. A section titled '\*Please check transactions that you submit and/or receive:' contains two columns of checkboxes for various transaction types, including 270 (Eligibility Inquiry), 271 (TPL Coverage Response), 276 (Claim Inquiry), 278 (Service Authorization Request), 834, 835, 835 TPL, 837D (Dental Claim), 837I (Institutional Claim), 837P (Professional Claim), 270 (TPL Coverage Inquiry), 271 (Eligibility Inquiry Response), 277 (Claim Inquiry Response), 278 (Service Authorization Response), 820 (Premium Payment), 824 (Exception Reporting), 834 (Managed Care Enrollment), 835 (Remittance Advice), 835 TPL, and 837.


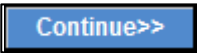
Step	Action
4.	<b>If submission is through a Vendor Software (X12 Transaction), the Provider will be acting as their own Trading Partner.</b>
Step	Action
5.	Click the <b>Vendor Software</b> option.
Step	Action
6.	Enter the desired information into the <b>Software Vendor Name</b> field.

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

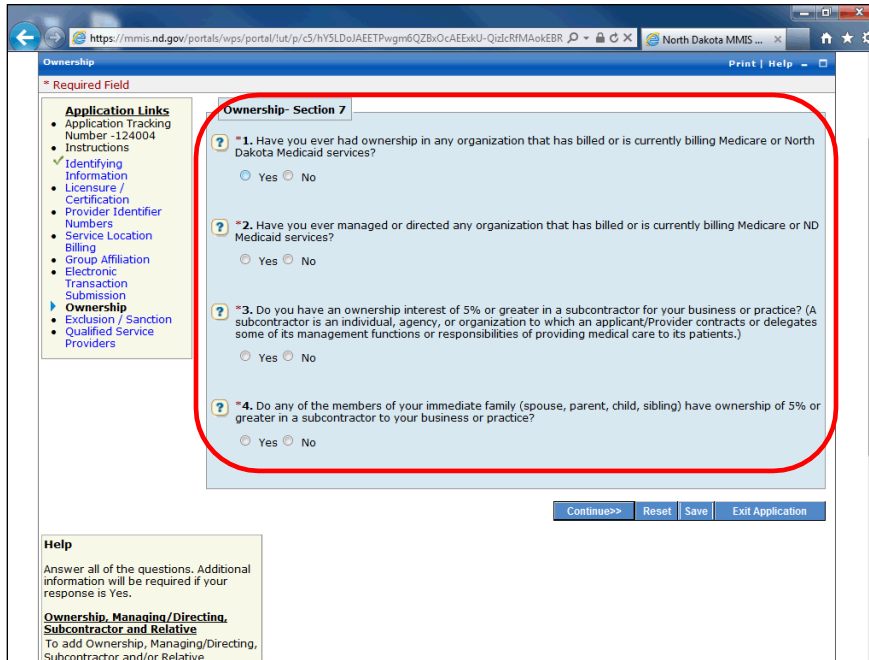


The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/!ut/p/c5/fYSJDoJAEEXPwgmqQKbnYAYNjBRpeNDXERIVf1cLpt>. The page title is "North Dakota MMIS". The main content area is titled "Indicate which of the following will be used to submit transactions electronically:". There are two radio button options: "North Dakota Health Enterprise Portal" (unchecked) and "Vendor Software" (checked). Under "Vendor Software", there is a checked option for "Billing Agent/Clearinghouse". Below this, there are several form fields: "Agent/Clearinghouse Name" (text input), "Contact First Name" (text input), "Contact Last Name" (text input), "Contact Phone #" (text input), "Street Address" (text input), "Street Address2:" (text input), "City:" (text input), "State" (dropdown menu showing "North Dako"), and "Zip Code:" (text input). At the bottom, there is a section titled "Please check transactions that you submit and/or receive:" with two columns of checkboxes. The "Submit" column includes: 270 (Eligibility Inquiry), 271 (TPL Coverage Response), 276 (Claim Inquiry), 278 Service Authorization Request, 834, 835, 835 TPL, and 837D Dental Claim. The "Receive" column includes: 270 (TPL Coverage Inquiry), 271 (Eligibility Inquiry Response), 277 Claim Inquiry Response, 278 Service Authorization Response, 820 (Premium Payment), 824 (Exception Reporting), 834 (Managed Care Enrollment), and 835 Remittance Advice. On the left side of the page, there is a "Help" section with the heading "Electronic Transaction Submission" and instructions: "Select one of the submission methods. Additional information will be required if the selection is Vendor Software or Billing Agent/Clearinghouse. Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button to move onto the next step. If you choose to Exit Application, please save and note the Tracking Number or print this page so you can make updates to this application at another time. If you have any questions, please contact Provider Enrollment at (800) 755-2604."

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

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

# Ownership Procedure



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

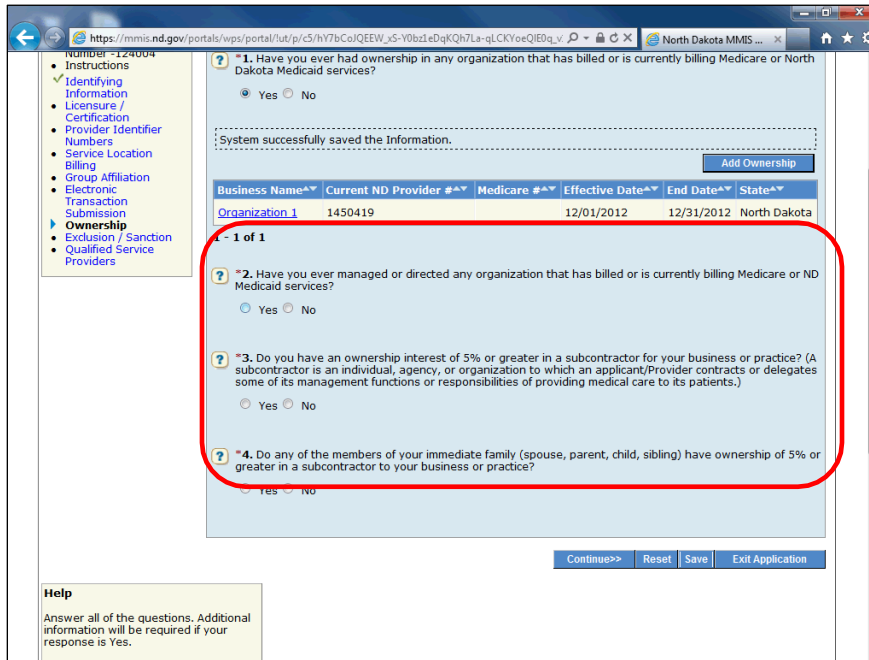
The screenshot shows a web browser window with the URL <https://mmis.nd.gov/portals/wps/portal/tul/p/c5/hy5jDoJAEEpVgmqQCaXSHcwkWSUImBDiANDZfgQ>. The page title is "North Dakota MMIS...". The main content area contains a form titled "Add Ownership Information" with a "Save | Reset | Cancel" link. The form is highlighted with a red circle. The form includes the following fields and options:


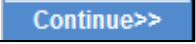
- Organization's Legal Business Name (text input)
- Effective Date (date input)
- End Date (date input)
- Address (text input)
- City (text input)
- State (dropdown menu, currently set to North Dakota)
- Zip (text input)
- EIN Number (text input)
- \*Please enter your NPI and/or Medicaid numbers. Indicate Medicare or Medicaid by checking a box below.
- NPI # (text input)
- Medicare (checkbox)
- Medicaid (checkbox)

Below the form, there are three questions with radio button options for Yes or No:

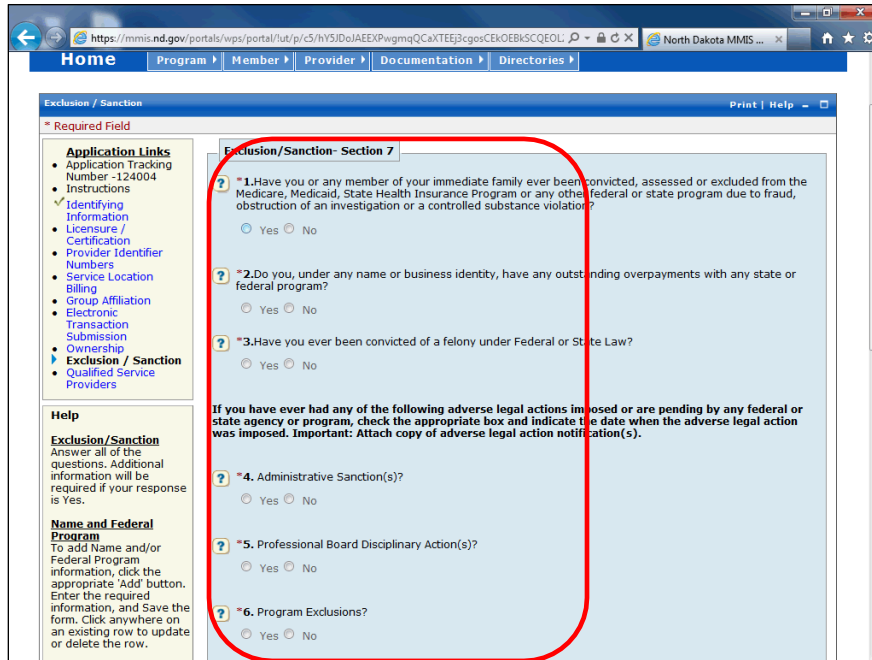
- Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services?
- Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services?
- Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates some of its management functions or responsibilities of providing medical care to its patients.)

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



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

# Exclusion/Sanction Procedure



**Exclusion / Sanction - Section 7**

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

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

\*3. Have you ever been convicted of a felony under Federal or State Law?  
 Yes  No

**If you have ever had any of the following adverse legal actions imposed or are pending by any federal or state agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed. Important: Attach copy of adverse legal action notification(s).**

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

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

\*6. Program Exclusions?  
 Yes  No

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

**Exclusion / Sanction**

**Required Field**

**Application Links**

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

**Help**

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

**Name and Federal Program**  
To add Name and/or Federal Program information, click the appropriate 'Add' button. Enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

**Date of Occurrence**  
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY

**Exclusion/Sanction- Section 7**

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

**Add Name** Add Name

Last Name^v	First Name^v	MI^v	Suffix^v	Relationship^v

**Add Family/Household Member Information** Save | Reset | Cancel


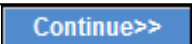
*Last Name	*First Name	MI	Suffix	*Relationship

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

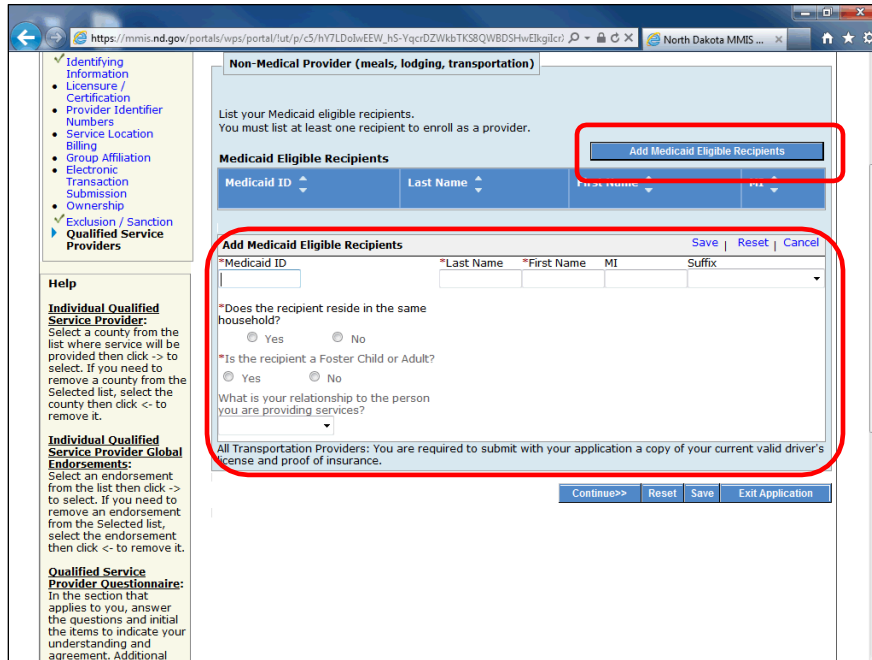
\*3. Have you ever been convicted of a felony under Federal or State Law?  
 Yes  No

**If you have ever had any of the following adverse legal actions imposed or are pending by any federal or state agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed. Important: Attach copy of adverse legal action notification(s).**



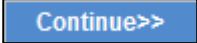
\*4. Administrative Sanction(s)?  
 Yes  No

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

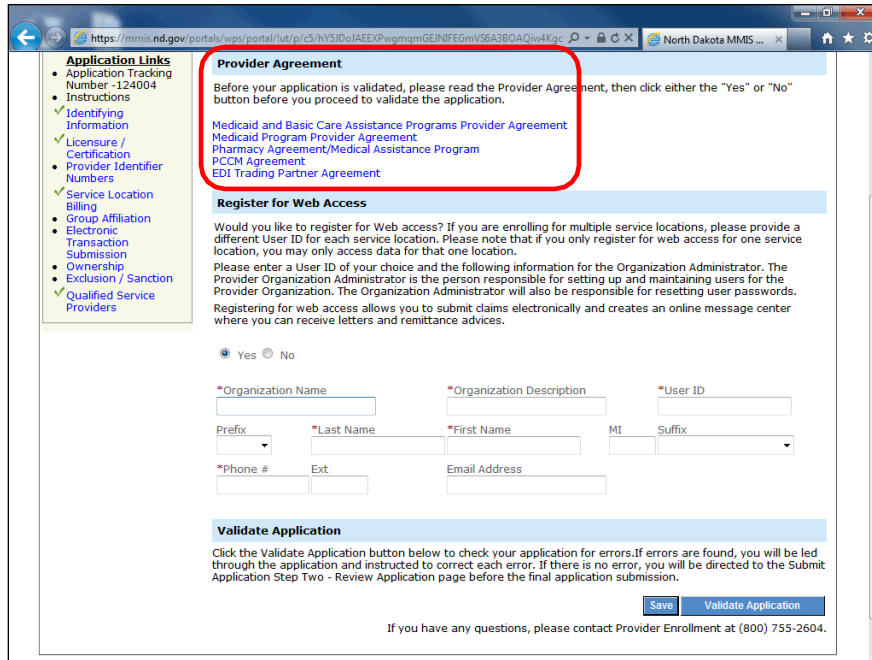
# Qualified Service Providers Procedure



Step	Action
1.	<p><b>If not enrolling as a Non-Medical Provider (QSP, Transportation, Meals, and Lodging providers), this section can be skipped.</b></p> <p>If you did not select Qualified Service Provider as a Provider Type or one of the following Specialties:</p> <ol style="list-style-type: none"> <li>1) Lodging</li> <li>2) Provide Meals</li> <li>3) Private Vehicle</li> <li>4) QSP</li> </ol> <p>This Section can be skipped.</p>
<b>Step</b>	<b>Action</b>
2.	<p>Click the <b>Add Medicaid Eligible Recipients</b> button.</p> <div style="border: 1px solid black; padding: 5px; text-align: center; width: fit-content; margin: 0 auto;"> <p><b>Add Medicaid Eligible Recipients</b></p> </div>
<b>Step</b>	<b>Action</b>
3.	Enter the desired information into the <b>Medicaid ID</b> field.
<b>Step</b>	<b>Action</b>
4.	Enter the desired information into the <b>Last Name</b> field.

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

# Submit Application Procedure



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

**Application Links**

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

**Provider Agreement**

Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.

Medicaid and Basic Care Assistance Programs Provider Agreement  
 Medicaid Program Provider Agreement  
 Pharmacy Agreement/Medical Assistance Program  
 PCCM Agreement  
 EDI Trading Partner Agreement

**Register for Web Access**

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.

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

Yes  No

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


Prefix  \*Last Name  \*First Name  MI  Suffix

\*Phone #  Ext  Email Address

**Validate Application**

Click the Validate Application button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error, you will be directed to the Submit Application Step Two - Review Application page before the final application submission.

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

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

Submit Application Step 1

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

**Application Links**

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

**Provider Agreement**

Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.

Medicaid and Basic Care Assistance Programs Provider Agreement  
Medicaid Program Provider Agreement  
Pharmacy Agreement/Medical Assistance Program  
PCCM Agreement  
EDI Trading Partner Agreement

**Register for Web Access**

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.

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

Yes  No

\*Organization Name: Smith Clinic  
\*Organization Description: Clinic  
\*User ID: [Redacted]

Prefix: [Dropdown]  
\*Last Name: SMITH  
\*First Name: TOM  
MI: [Dropdown]  
Suffix: [Dropdown]

\*Phone #: 701-555-5555  
Ext: [Text]  
Email Address: [Text]

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

Submit Application Step 1

**Application Links**

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

**Provider Agreement**

Before your application is validated, please read the Provider Agreement, then click either the "Yes" or "No" button before you proceed to validate the application.

Medicaid and Basic Care Assistance Programs Provider Agreement  
Medicaid Program Provider Agreement  
Pharmacy Agreement/Medical Assistance Program  
PCCM Agreement  
EDI Trading Partner Agreement

**Register for Web Access**

Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.

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

Yes  No

\*Organization Name: Smith Clinic  
\*Organization Description: Clinic  
\*User ID: TOMSMITH


Prefix: [Dropdown]  
\*Last Name: SMITH  
\*First Name: TOM  
MI: [Dropdown]  
Suffix: [Dropdown]

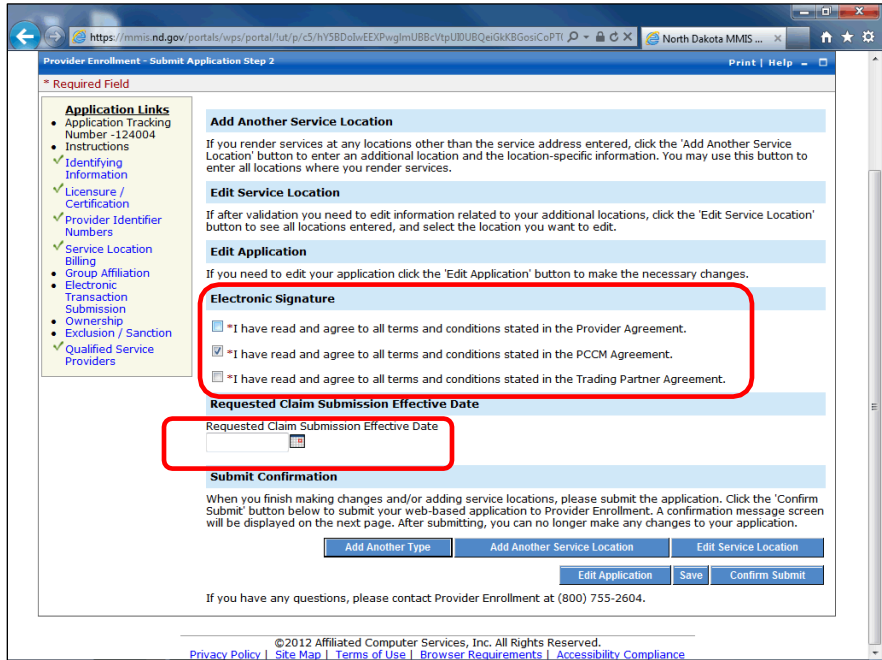
\*Phone #: 701-555-5555  
Ext: [Text]  
Email Address: [Text]


**Validate Application**

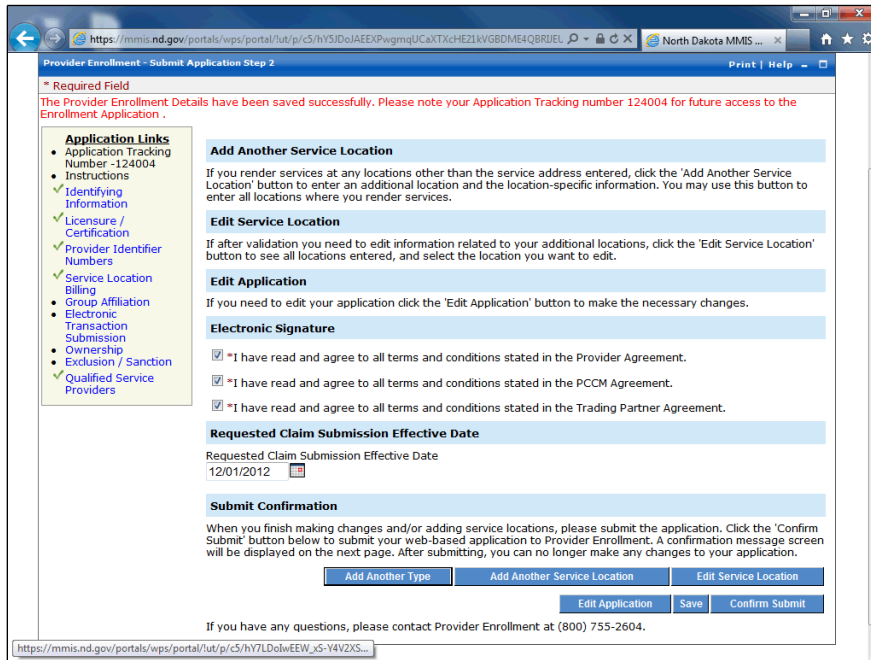
Click the Validate Application button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error, you will be directed to the Submit Application Step Two - Review Application page before the final application submission.

Validate Application

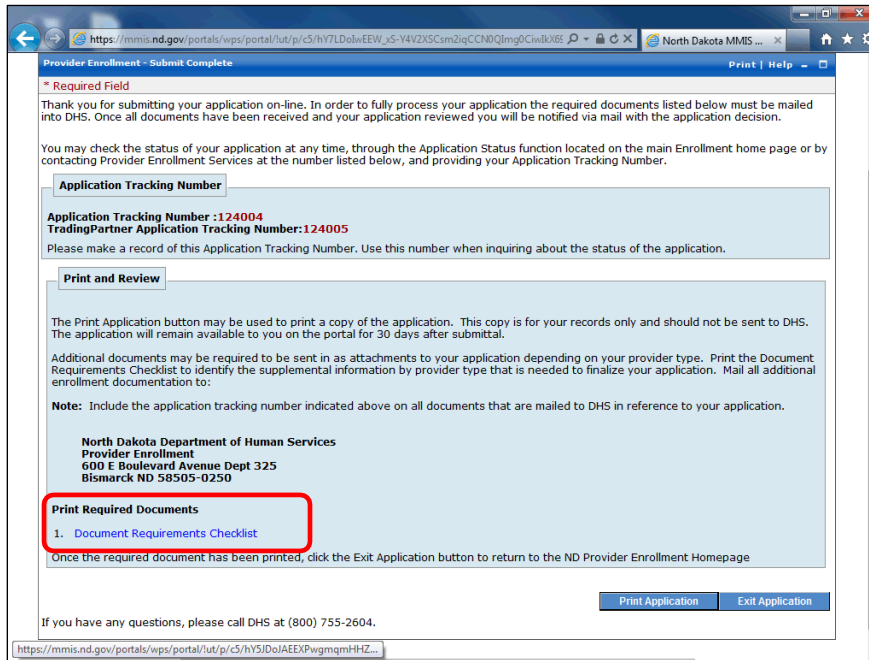
Step	Action
11.	Click the <b>Validate Application</b> button. This will check the application for errors. 



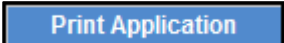
Step	Action
12.	Click the required <b>Electronic Signature</b> options.
Step	Action
13.	Enter the <b>Requested Claim Submission Effective Date</b> .
Step	Action
14.	Click the <b>Save</b> button. 



Step	Action
15.	<b><u>Review the application for accuracy and completeness before submitting the application.</u></b>
Step	Action
16.	<b>Add Another Type and Add Another Service Location should <u>never</u> be used on an individual application. If the individual has more than one provider type, then a separate application is required. If the individual practices at multiple locations, then use the group affiliations page to associate all locations.</b>
Step	Action
17.	<b>If you click the Confirm Submit option, you will not be able to make any further edits to the application.</b>
Step	Action
18.	Click the <b>Confirm Submit</b> button if you have no edits or updates to make to the application. <div style="text-align: center; border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Confirm Submit</b> </div>



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



North Dakota Department of Human Services  
Individual Provider Enrollment Application

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

**Identifying Information – Section 1**

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

**Current/Previous ND Provider #**

Current and/or previous ND Provider number: 000012545

**Previous Names**

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

**License and Certification – Section 2**

Provider Type: Physician

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

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

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

**Application Tracking Number**

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

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

**Print and Review**

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

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

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

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


**Print Required Documents**

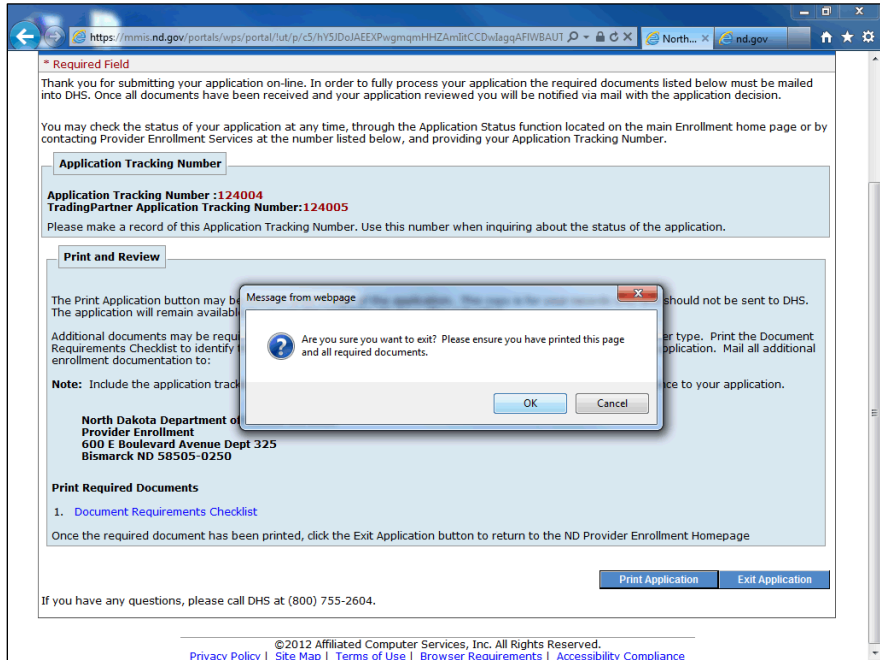
1. [Document Requirements Checklist](#)

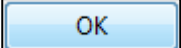
Once the required document has been printed, click the Exit Application button to return to the ND Provider Enrollment Homepage

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

<https://mmis.nd.gov/portals/wps/portal/ut/p/c5/hY5JDoJAEXpWgmqGBuX...> mputer Services, Inc. All Rights Reserved.  
[Use | Browser Requirements | Accessibility Compliance](#)

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



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