

Health & Human Services

Provider Enrollment Coversheet

Date Submitted:	
Provider Name:	
Application Tracking Number: (New Applications Only)	
Medicaid ID Number: (if applicable)	
NPI #:	
Medicare Number: (if applicable)	
Contact Person/Title:	
Phone number:	
Email:	

Service Information (revalidation, reactivation, or change)

Website _____

Age Ranges Served

All	0-5 Years	6-12 Years	13-17 Years
18-21 Years	22-59 Years	60+ Years	

Gender Served

Accepting New Patients

Provides Telehealth

340b Provider

Languages Supported (other than English) _____

Hours of Operation (if different than Monday – Friday 9am – 5pm) _____

Special Needs (check all that apply)

Behaviorally Disruptive	Developmentally Disabled	
Hearing Impaired/Deaf	HIV/AIDS	Mental Health Disabilities
Other Special Needs	Physically Handicapped	Sexually Aggressive
Vision Impaired/Blind	Substance Abuse	

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Accommodations

Handicap Accessible Offices **Braille** **Oral** **Sign** **Other**
Handicap Accessible Exam Rooms Equipment **TDD-TTY #** _____

Document(s) submitted for: (please check all that apply)

- New Application
- Revalidation
- Reactivation
- Address Change (SFN 1299)
- Affiliation (SFN 1330)
- Change of Ownership/Controlling Interest Conviction Information (SFN 1168)
- Contact Information Update
- EFT Request/Update (SFN 661)
- Name Change
- NPI Change
- Taxonomy Update (SFN 1302)
- Termination (SFN 1331)
- Service Information
- Critical Access Hospital (CAH) conversion to Rural Emergency Hospital (REH)
- Audit Contact

Documents may be submitted to:

Email: NDMedicaidEnrollment@Noridian.com

Fax: 701-433-5956 ATTN: NDM Provider Enrollment

Mail: Noridian Healthcare Solutions

Attn: ND Medicaid Provider Enrollment

PO Box 6055

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