

Health & Human Services

**Rehabilitation, Substance Use Disorder Hospital Unit (027-623)
ASAM 3.7 Services Only
Group Application Requirements**

ND Medicaid does not enroll Out of State SUD Hospital Units due to the service being available in state.

Type of Application:

Date submitted: _____

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

Section 1: Group Information

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

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

YES NO

*If Yes- List additional service locations below (must have the same Provider Type, NPI, EIN, and billing address).

Address	City	State	Zip Code

2. Are you Medicare enrolled? **YES NO** * Medicare Enrollment is required
Medicare ID: _____

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3. 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 Noridian 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**

4. 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 disabilities, dementia and neurocognitive disorders such as Alzheimer's disease. Substance use disorders are considered a mental disease.

YES **NO**

If yes, answer questions below.

a. 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 is asking about number of beds, not number or rooms. If there are rooms with more than one bed, each bed must be counted).

b. Does your facility have specific beds or units that are allocated for services for individuals with mental diseases? **YES** **NO**

c. How many beds are typically used for inpatient services for individuals with mental diseases? _____

d. Does your facility ever adjust the number of beds allocated for inpatient services for individuals with mental diseases? **YES** **NO**

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- e. Does your organization or governing body have any additional facilities that provide residential or inpatient services to individuals with mental diseases?
YES NO

If yes, provide a list with the addresses of each location.

Address	City	State	Zip Code

Provider Type 027-Hospital Units
Specialty 364-Rehabilitation, Substance Use Disorder Unit
Taxonomy 276400000X

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

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

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

Section 2: Required Documents:

1. Group Application Requirements

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2. CP 575 or 147C (*Not required if submitting a FEDERAL tax-exempt letter issued by the IRS)

- The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter providers receive from the IRS granting their Employer Identification Number (EIN). The 147C is a replacement letter from the IRS verifying your Legal Business Name and Tax ID. This letter can be used in place of a CP 575. If unable to locate either of these letters, visit [Lost or Misplaced Your EIN? | Internal Revenue Service \(irs.gov\)](#) for direction.

3. IRS Tax Exempt Letter-501(C3) (*If Exempt from FEDERAL Taxes)

**A State issued letter cannot be substituted. The letter must be issued by the IRS.*

- For more information, refer to: [Governmental Information Letter | Internal Revenue Service \(irs.gov\)](#)

4. Hospital License

5. Unit License

6. Program license (SUD treatment provider/program)

7. [SFN 661](#) - Electronic Funds Transfer (EFT)

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

8. [SFN 1168](#) - Ownership/Controlling Interest and Conviction Information

- List of Managing Employees attached to Section IV (Page 2) with dates of birth and SSNs.
- List of Board Members attached to Section IV (page 2) with dates of birth and SSNs.

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9. [SFN 615](#) - Medicaid Program Provider Agreement
* *Must be signed and dated by a Managing Employee*

Application may be submitted by:

Email: NDMedicaidenrollment@noridian.com

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

Mail: Noridian Healthcare Solutions

Attn: ND Medicaid Provider Enrollment

PO Box 6055

Fargo, ND 58108-6055

For questions concerning Provider Enrollment, please contact (877) 328-7098 (toll-free) or (701) 328-7098. Live support 8 a.m. - 5 p.m. CT, Monday – Friday.