



### 1915(i) GROUP ATTESTATION

Group Name (printed): \_\_\_\_\_ Group NPI: \_\_\_\_\_

As an entity enrolling to provide 1915(i) services under the North Dakota Medicaid Program, I attest that I understand and will adhere to all 1915(i) state and federal standards and requirements as outlined in the North Dakota Medicaid State Plan, including, but not limited to the following:

- All individual practitioner providers of services to Medicaid recipients meet required qualifications.
- All individual practitioner providers of services have required competencies.
- All services provided will be within the scope of practice of the individual provider.
- Will conduct training per state policies/procedures.
- All enrolled Medicaid providers and providers who have applied for Medicaid enrollment will adhere to all 1915(i) standards and requirements.
- Required policies are available for NDDHS review.

Provider Facility/Organization Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name of Authorized Representative

**Attestation must be signed, dated, and returned by email to [NDMedicaidEnrollment@noridian.com](mailto:NDMedicaidEnrollment@noridian.com) or by fax to 701-433-5956.**

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.