# 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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August 2023

# North Dakota Department of Human Services Group Provider Application Checklists

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Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #							
		Provider Name							
	ition	Organizational NPI # (Not Required)							
	rma	Service Address							
	Infor	Billing Address							
Section	ngl	Mailing Address							
Se	ifying	Facility Phone							
	denti	Contact Person							
	0	Phone							
		Email							
			If yes, please include Type, NPI, EIN, and Please note: Service add the same record as out of been provided at each lo	billing address resses located wi of state service lo	i <b>).</b> ithin North Dako	a and bordering citi	ies (within 50 miles of t	he ND border) cannot be	enrolled in
n 2:	ons	2. Are you exempt from I	FEDERAL taxes?	□ YES		If Exempt from FE	EDERAL Taxes, submit y	our IRS issued Tax Exem	pt Letter.
Section	ne	3. Do you have any Indivi (Interest may be direct o		which have 59	% or more inte	rest in the enrol	ling group?	☐ YES	🗆 NO
Š	q	4. How many Managing E If more than 3 Managing Empl List must contain First Names,	oyees, attach a list as pa	rt of Section III o			have?		
		5. Are you organized as a corporation?	corporation, a non-	profit corpora	tion, or a gove	rnment agency	organized as a	☐ YES	□ NO
			5a. If Yes, how man If more than 3 Board M (page 2).	-	-		168		
		6. Is your establishment h for pay to transient guest	•	as a place wh	ere sleeping a	ccommodations	are furnished	□ YES	□ NO

		The documents requeste	The documents requested below must be returned to the Department in order to process your enrollment										
		Please ensure you use th Outdated versions of for	Helpful Links	Submitted									
	ents	1. <u>Coversheet for Fax/En</u>	<u>Coversheet for</u> <u>Fax/Email</u>										
 	Sume	2. Group Application Che											
tion	Doc	3. List of Service Location											
Secti	uired	4. <u>SFN 620 (12-2021)</u>	Provide the date business was formed (aproximate date i	is accepted):	<u>SFN 620 (12-2021)</u>								
	Requ	5. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing Employee:		<u>W-9 (10-2018)</u>								
		6. CP 575/147C (Not requ	ired if submitting a FEDERAL tax exempt letter issue	ed by the IRS)	<u>What is the</u> <u>CP575/147C?</u>								

nued	7. IRS Tax Exempt Letter (Re If Ex can	IRS Tax Exempt Letter for Government Agencies						
Continued	8. License - Issued by the ND updated licensure information on renewed)							
3: nts	License #		Issued:		Expires:			
on Ö								
Section	9. <u>SFN 661 (12-2022)</u> Prin	<mark>nted Name of Signi</mark>	<mark>ng Managing Em</mark> p	oloyee:			<u>SFN 661 (12-2022)</u>	
	9a. Bank Letter/Voided	Check	Must match the I	nformation pro	vided on the SFN 661	1		
q q								
Required	10. <u>SFN 1168 (8-2020)</u>						Simplified Instructions	
nba							based on FAQs	
Re	10a. List of Managing Em	nployees attached	to Section III (Pag	e 2) with dates	of birth and SSNs			
	10b. List of Board Memb	10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.						
	11. SFN 615 (6-2023) Prin	nted Name of Signi	ng Managing Emp	oloyee:			SFN 615 (6-2023)	
	Proof of Insurance is not require	ed for any applicat	ion. If proof of ins	urance is submi	tted with an applicati	ion, it will be delet	ted from the file. It remair	าร
	provider's responsibility to ensu	ure that the necess	ary insurance is i	n place, but pro	of of insurance is no	t required to be s	ubmitted for any applicat	ion.
	PROVIDER TYPE     017-Other Service Providers							
	SPECIALTY 339-Lodging							
ate	TAXONOMY N/A	A						
Please coordinate with your billing department and any other applicable area to determine the correspondence of the enrollment effective date. The Department will not make changes to that date once the application of the enrollment effective date is limited to no more than ninety (90) days prior to the enrollment effective date is limited to no more than ninety (90) days prior to the enrollment effective date assigned will be 90 days from the date the complete application packet is received by the Department. If the date requested is outside the 90 days from the date the complete application packet application packet assigned will be 90 days from the date the complete application packet application packet application packet application by the Department.								
S. Enrollme	Requested Enrollment Effect Printed Name of Person	tive Date						l
	Requesting the Effective Date				Date			
	Click Here to find	d more informati	on on Effective	Dates and Ret	ro Effective Date P	olicies		
	Revision 8/2	22/2023						

# Group Application Checklist Meals (017 - 393)

#### Have Questions? <u>Click Here</u> for FAQs and More Resources

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

	Application Tracking #							
	Provider Name							
on 1: Information	Organizational NPI # (Not Required)							
1: prmä	Service Address							
on ) nfo	Billing Address							
Section ying Inf	Mailing Address							
Seifyi	Facility Phone							
S dentify	Contact Person							
-	Phone							
	Email							
n 2: ons	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.							
Section Questic	3. Do you have any Individu (Interest may be direct or in		which have 5% or more into	rest in the enrolling group	?	□ YES	🗆 NO	
х д	<b>4. How many Managing Emp</b> If more than 3 Managing Employe List must contain First Names, Las	ees, attach a list as pa	rt of Section III of the SFN 1168 (p	• •				
	5. Are you organized as a co corporation?	prporation, a non-	profit corporation, or a gove	rnment agency organized a	as a	□ YES	□ NO	
	lf m		y Board Members do you ha embers, attach a list as part of Sec					
	The documents requested b	pelow must be ret	urned to the Department in	order to process your enro	ollment			
	Please ensure you use the li Outdated versions of forms	inks provided to o	btain the current versions c			Helpful Links	Submitted	
	1. <u>Coversheet for Fax/Email</u>	<u> </u>				Coversheet for Fax/Email		

2. Group Application Checklist

lent	2. Group Application Ch		````		
3: um	3. List of Service Locatio	ns (Required if you answered Yes to question 1 abo	ove)		
Doc	4. <u>SFN 620 (12-2021)</u>	Provide the date business was formed (aproximate da	te is accepted):	<u>SFN 620 (12-2021)</u>	
Sect	5. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing Employee:		<u>W-9 (10-2018)</u>	
Regu	6. CP 575/147C (Not red	<u>What is the</u> <u>CP575/147C?</u>			
	7. IRS Tax Exempt Lette	IRS Tax Exempt Letter for			
		Government Agencies			

hed										
tint	8. <u>SFN 661 (12-2022)</u> Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>								
Continued	8a. Bank Letter/Voided Check Must match the Information provided on the SFN 661									
Section 3: Required Documents	9. <u>SFN 1168 (8-2020)</u>	Simplified Instructions based on FAQs								
	9a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs									
	9b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.									
Req	10. SFN 615 (6-2023) Printed Name of Signing Managing Employee:	<u>SFN 615 (6-2023)</u>								
	Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be delet provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be s									
	PROVIDER TYPE 017-Other Service Providers									
	SPECIALTY 393-Provide Meals									
e E	TAXONOMY N/A	TAXONOMY N/A								
Section 4: Iment Effective Date	Please coordinate with your billing department and any other applicable area to determin enrollment effective date. <b>The Department will not make changes to that date once</b> <b>is approved</b> and any claims submitted with a date of service prior to the enrollment effective deny. A retroactive enrollment effective date is limited to no more than ninety (90) days p <b>complete</b> application packet is received by the Department. If the date requested is out timeframe, the enrollment effective date assigned will be 90 days from the date the com packet was received.	e the application ective date will prior to the date a side the 90 day								
Enro	Requested Enrollment Effective Date									
	Printed Name of Person Requesting the Date Effective Date									
	Revision 8/22/2023									

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

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

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

		Application Tracking #							
		Provider Name							
	tion	Organizational NPI # (Not Required)							
	σ	(not negative)							
÷;	orm	Service Address							
on	Info	Billing Address							
Section		Mailing Address							
	ifying	Facility Phone							
	denti	Contact Person							
	0	Phone							
		Email							
			If yes, please includ Type, NPI, EIN, and Please note: Service add the same record as out been provided at each lo	e a list with the billing address Iresses located wi of state service loo	e addresses of al ). thin North Dakota d	l service location	within 50 miles of th	e ND border) cannot b	e enrolled in
יא ר ז	ons	2. Are you exempt from I	FEDERAL taxes?	□ YES		f Exempt from FEDEI	<mark>RAL</mark> Taxes, submit yo	our I <mark>RS</mark> issued Tax Exen	npt Letter.
Section	uestic	3. Do you have any Indivi (Interest may be direct o		which have 5%	6 or more intere	st in the enrolling	g group?	🗌 YES	□ NO
Š	a	4. How many Managing E If more than 3 Managing Empl List must contain First Names,	oyees, attach a list as pa	rt of Section III of		•••	ve?		
		5. Are you organized as a corporation?	corporation, a non-	profit corpora	tion, or a govern	ment agency org	anized as a	□ YES	
			5a. If Yes, how man If more than 3 Board M (page 2).	•	•				
		6. Is your establishment h for pay to transient guest	•	c as a place wh	ere sleeping acco	ommodations are	e furnished	☐ YES	□ NO

 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.

	nts	1. <u>Coversheet for Fax/Er</u>	nail	<u>Coversheet for</u> <u>Fax/Email</u>	
 	ume	2. Group Application Ch	ecklist		
Ion	Doc	3. List of Service Locatio	ns (Required if you answered Yes to question 1 above)		
Sect	uired	4. <u>SFN 620 (12-2021)</u>	Provide the date business was formed (aproximate date is accepted):	<u>SFN 620 (12-2021)</u>	
	Requ	5. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>	
		6. CP 575/147C (Not req	uired if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>	

	7. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above)								
		If Exempt from FEDERA	•		•	issued letter	IRS Tax Exempt Letter for		
		cannot be substituted.					Government Agencies		
ed									
Continued	8. License - Issued by the	e ND Dept of Health	for ND provider	s) (It is the respon	sibility of the provide	r to keep			
i i i	updated licensure informatio								
u l	renewed)				-				
U U	License #	<b>#</b>	Issued:		Expires:				
·· · ·									
n 3: ents				_					
Section	9. <u>SFN 661 (12-2022)</u>	Printed Name of Sign	ing Managing Em	nployee:			<u>SFN 661 (12-2022)</u>		
u Cti	9a. Bank Letter/Vo	ided Check	Must match the	Information pro	wided on the SFN 66	1			
Sectio						-			
DO N									
σ	10 (55) 11(0 (0 2020)						<b>Simplified Instructions</b>		
e	10. <u>SFN 1168 (8-2020)</u>						based on FAQs		
tequired	10a. List of Managin	10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs							
Ř	10h List of Board M	ampana attached to Co	ation III (Daga 2)	with datas of him	th and CCNa				
	10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.								
	11. <u>SFN 615 (6-2023)</u>	Printed Name of Sign	ing Managing Em	ployee:			SFN 615 (6-2023)		
	Proof of Insurance is not reprovider's responsibility to								
	PROVIDER TYPE	017-Other Service Pro	viders						
	SPECIALTY	339-Lodging	393-Provide M	eals					
ں ا	ΤΑΧΟΝΟΜΥ	N/A							
ate									
Δ	Please coordinate w	ith your billing de	partment an	nd any other	applicable area	to determine	e the correct		
ve Ve	enrollment effective								
ion 4: Effective	is approved and an								
ec ec	deny. A retroactive								
Section ent Effe	complete application								
	timeframe, the enro						· · · · · · · · · · · · · · · · · · ·		
en ee	packet was received		ale assigned	u will be 90	uays nom the t				
ja v	packet was received	•						J	
				1					
Sect Enrollment	Requested Enrollment E	ffective Date							
Ц	Printed Name of								
	Person Requesting the				Date				
	Effective Date				Date				
	Revision	8/22/2023							

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

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #							
	_	Provider Name							
	Information	Organizational NPI #							
	nat								
	lor	Service Address	Only 1 service locat	ion may be oproll	ad par Madica	id ID			
tior		Billing Address	Only I service locat	ion may be enrolle		IU ID.			
Section	/ing	Mailing Address							
	ntify	Facility Phone							
	ldentifying								
	_	Contact Person							
		Phone							
		Email							
		1 Are you even t from F	EDERAL toyog?			If Exampt from EEDER	N Taxos submit vou	ır I <mark>RS</mark> issued Tax Exempt I	ottor
		1. Are you exempt from F				-			letter.
		2. Do you have any Indivi (Interest may be direct o		es which have 59	% or more in	terest in the enroll	ing group?	□ YES	□ NO
2:	ns			•		h			
ction	stio	3. How many Managing E If more than 3 Managing Empl	loyees, attach a list as	part of Section III o			ave?		
Sect	Sue	List must contain First Names,	, Last Names, Dates of	Birth, and SSNs					
S	0	4. Are you organized as a corporation?	corporation, a no	n-profit corpora	tion, or a gov	vernment agency o	organized as a	□ YES	□ NO
			4a. If Yes, how ma	•	-				
			If more than 3 Board 1168 (page 2).	Members, attach a	list as part of S	ection III of the SFN			
		I have read and acknowle	edge that I unders	tand the followi	ng: Affiliatio	ns (separate indivi	dual	Enter Initials	below
		enrollments) are required etc.) and the individual re		-	-		•	(required for enr	ollment)
		must be linked ("affiliate	d") to the billing p	rovider record i	n the system	. For all rendering	providers who		
		are not actively enrolled application is approved.	in ND Medicaid, ir	ndividual applica	ations should	l be submitted bef	ore the group		
		The documents requeste	d below must be r	eturned to the D	Department i	n order to process	your enrollment	:	
		Please ensure you use the Outdated versions of for			ent versions	of each form.		Helpful Links	Submitted
	S	1. Coversheet for Fax/Em						Coversheet for	
	ents							<u>Fax/Email</u>	
:: ::	n	2. Group Application Che	cklist						
	Doc	3. <u>W-9 (10-2018)</u>	Printed Name of Sig	gning Managing E	mployee:			<u>W-9 (10-2018)</u>	
Section								What is the	
Se	uired	4. CP 575/147C (Not requ	ired if submitting	a FEDERAL tax e	exempt letter	r issued by the IRS)		<u>CP575/147C?</u>	
	edr	5. IRS Tax Exempt Letter	(Required if you a	nswered Yes to o	question 1 al	oove)		IRS Tax Exempt Letter	
	8		If Exempt from FEDER cannot be substitute	-		Fax Exempt Letter. A St e I <mark>RS</mark> .	tate issued letter	for Government Agencies	
					•				

Page 2	2 of 2
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ued	6. NPI prinout from the <u>NPPES Website</u>	NPPES Website						
i 3: nts Continued	7. SFN 661 (12-2022)       Printed Name of Signing Managing Employee:         7a. Bank Letter/Voided Check       Must match the Information provided on the SFN 661	<u>SFN 661 (12-2022)</u>						
Section 3: Documents	8. <u>SFN 1168 (8-2020)</u>	Simplified Instructions based on <u>FAQs</u>						
	8a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs							
Required	8b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.							
Re	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 b provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to							
	PROVIDER TYPE     017-Other Service Providers							
	SPECIALTY     468-County Social Service Office							
	TAXONOMY         171M00000X							
ion 4: Effective Date	Please coordinate with your billing department and any other applicable area to deter enrollment effective date. <b>The Department will not make changes to that date application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more days* prior to the date a <b>complete</b> application packet is received by the Departmen requested is outside the 90 day timeframe, the enrollment effective date assigned wi from the date the complete application packet was received.	once the le enrollment than ninety (90) t. If the date						
4: ctive	enrollment effective date. <b>The Department will not make changes to that date</b> application is approved and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more days* prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned with	once the be enrollment than ninety (90) t. If the date ill be 90 days ys prior to the date a ication documents.						
4: ective	enrollment effective date. <b>The Department will not make changes to that date of</b> <b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more days* prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned we 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 date complete application packet is received. You must include a copy of the claim and medical records with your apple	once the be enrollment than ninety (90) t. If the date ill be 90 days ys prior to the date a ication documents.						
4: ctive	enrollment effective date. <b>The Department will not make changes to that date of application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more days* prior to the date a <b>complete</b> application packet is received by the Departmen requested is outside the 90 day timeframe, the enrollment effective date assigned w 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 da complete application packet is received. You must include a copy of the claim and medical records with your appl This application is associated with an emergency service. We are requesting the date of	once the be enrollment than ninety (90) t. If the date ill be 90 days ys prior to the date a ication documents.						
4: ctive	enrollment effective date. The Department will not make changes to that date of application is approved and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more days* prior to the date a complete application packet is received by the Departmen requested is outside the 90 day timeframe, the enrollment effective date assigned w 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 da complete application packet is received. You must include a copy of the claim and medical records with your appl This application is associated with an emergency service. We are requesting the date of	once the he enrollment than ninety (90) t. If the date ill be 90 days ys prior to the date a ication documents. . Refer to the * above.						

# Group Application Checklist Community Behavioral Health (025 - 357)

# Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #									
	Provider Name									
ion	Organizational NPI #									
Section 1: dentifying Information										
1: orn	Service Address									
Section 1: ying Inforr	Billing Address									
ecting	Mailing Address									
S. ifyi	Facility Phone									
ent										
lde	Contact Person									
	Phone									
	Email									
			NO			•				
	1. Are you Enrolled in Me Please Provide	our Medicare ID:		☐ YES						
	Is your Medicare Re				☐ YES					
			CL - L - D			]				1
	2. Are you Enrolled in Me State Abbv:		State?	Please P	NO 🗌 NO rovide your Other St	YES				
				T TCGSC T						
	3. Are you enrolling any a	additional service l	ocations not l	listed above	at this time?			YES		10
ר 2: ons		If yes, please inclu Provider Type, NF			es of all service locat	ions being enroll	ed (mus	st have the	same	
ection		Please note: Service a	ddresses located	l within North D	, Dakota and bordering citie Dut of state service locatio	•		•		ed
Section Questio		services have been pr						out of state i	ccorary	
0,0	4. Are you exempt from I	FEDERAL taxes?	□ YES		If Exempt from FEDER	AL Taxes, submit you	ur <mark>IRS</mark> issu	ied Tax Exen	ıpt Letter.	
	5. Do you have any Indiv	iduals or Business	es which have	e 5% or more	interest in the enrol	ling group?		VEC		
	(Interest may be direct o	or indirect)						YES		NO
	6. How many Managing I	Employees (autho	rized to sign o	n behalf of t	he business) do you l	have?				
	If more than 3 Managing Emp List must contain First Names	=	-		168 (page 2).					
	7. Are you organized as a corporation?	i corporation, a no	n-profit corpo	oration, or a	government agency of	organized as a		YES		NO
		7a. If Yes, how main of the second se	-	-						
		SFN 1168 (page 2).	Weinbers, attac	in a list as part	or section in or the					
	I have read and acknowle	edge that I unders	tand the follo	wing: Affilia	tions (separate indiv	vidual		Enter Initia	als below	,
	enrollments) are required		-			• • • •		quired for e		
	etc.) and the individual re must be linked ("affiliate									
	are not actively enrolled	in ND Medicaid, in	ndividual appl	lications sho	uld be submitted be	fore the group				
	application is approved.									

				aturnad to the	- Donortmont	:			
		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 for						Helpful Links	Submitted
		1. Coversheet for Fax/Em						<u>Coversheet for</u> Fax/Email	
								Fax/ Ellidii	
		2. Group Application Che	ecklist						
		3. List of Service Location	ns (Required if you	answered Yes	s to question 3	above)			
		4. <u>W-9 (10-2018)</u>	Printed Name of S	igning Managing	g Employee:			W-9 (10-2018)	
		+. <u>W-5 (10-2016)</u>			g Linployee.			<u></u>	
	ents	5. CP 575/147C (Not requ	ired if submitting	a FEDERAL tax	x exempt lette	r issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>	
	ue Ue	6. IRS Tax Exempt Letter	(Poquirod if you a	nsworod Vos t	o question 1 a	hova		IRS Tax Exempt Letter	
ר 3:	Docum	o. INS Tax Exempt Letter	If Exempt from FEDE	RAL Taxes, submit	t your <mark>IRS</mark> issued	Tax Exempt Letter. A St	ate issued letter	for Government	
Section	00		cannot be substitute	d. The letter mus	t be issued by the	e IRS.		<u>Agencies</u>	
ect	ired	7. Agency License (It is the state by submitting a copy of the second state by submitting a copy of the second state by submitting a copy of the second state stat					n file with the		
5		License #	•	Issued:		Expires:			
	Seq	8. NPI prinout from the N	IPPES Website					NPPES Website	
		9. <u>SFN 661 (12-2022)</u>	Printed Name of S					<u>SFN 661 (12-2022)</u>	
		9a. Bank Letter/Vo	ded Check	Must match th	ne Information	provided on the SFN 6	661		
		10 CEN 11CO (0 2020)						Simplified Instructions based on	
		10. <u>SFN 1168 (8-2020)</u>						FAQs	
		10a. List of Manag	ing Employees atta	ched to Section	III (Page 2) with	dates of birth and SS	Ns		
		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 S	igning Managing	g Employee:			SFN 615 (6-2023)	
		Proof of Insurance is not red	quired for any appli	cation. If proof o	of insurance is su	ubmitted with an appl	lication, it will be o	deleted from the file. It	remains the
		provider's responsibility to	ensure that the neo	cessary insuranc	e is in place, bu	t proof of insurance i	s not required to l	pe submitted for any ap	oplication.
		PROVIDER TYPE	025-Agencies						
		SPECIALTY TAXONOMY	357-Community/Be	ehavioral Health					
				omv? Click He	re to find mor	e information on Ta	xonomies		
	(D	Already Know your						our Taxonomy	
	)ate	https://www.hhs.r	nd.gov/sites/www	/files/docume	ents/DHS%20L	egacy/mmis-group-	provider-code-ta	axonomy.pdf	
	e D	Please coordinate wi	th vour billing	department	and any ot	her applicable a	rea to determ	nine the correct	
÷:	Effective	enrollment effective	date. The De	partment v	vill not ma	ke changes to	that date of	nce the	
	ffe	application is appr effective date will de							
Section 4:	nt E	days* prior to the da							
Se	men	requested is outside from the date the co					assigned will	be 90 days	
		****			<b>_</b>				
	Ö	*If this application is associ complete application packet							
	Enroll	This application is	associated with an	emergency serv	vice. We are req	uesting the date of		Refer to the * above.	
	Enr	This application is	associated with an	emergency serv	vice. We are req	uesting the date of	I	Refer to the * above.	
	ш	Requested Enrollment Ef		emergency serv	vice. We are req	uesting the date of	I	Refer to the * above.	
	ш			emergency serv	vice. We are req	uesting the date of Date	·	Refer to the * above.	

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

		Application Tracking #			
		Provider Name			
	tion	Organizational NPI #			
	at				
;;	orm	Service Address			
ion		Billing Address			
Section	ing	Mailing Address			
S	itifying	Facility Phone			
	en				
	Ide	Contact Person			
		Phone			
		Email		 	

	1. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?)	□ YES							
ction 2: estions	2. Are you enrolling any additional service locations not listed above at this time? If yes, please include a list with the addresses of all service locations being enrolled (must Type, NPI, EIN, and billing address). Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the NE same record as out of state service locations. Out of state service locations will only be enrolled in an out o provided at each location.	) border) cannot be enr	olled in the						
Section Questio	3. Are you exempt from FEDERAL taxes? I YES INO 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							
	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							
	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).								
		Enter Initials below quired for enrollmei							

									Page Z			
		The documents requeste	ed below must be re	eturned to the Dep	artment in ord	ler to process you	r enrollment					
		Please ensure you use th	Helpful Links	Submitted								
		Outdated versions of for		epted.				Coversheet for				
		1. <u>Coversheet for Fax/En</u>	nail					Fax/Email				
		2. Group Application Ch	ecklist									
		3. List of Service Locatio	ons (Required if you	answered Yes to q	uestion 2 abo	ve)						
		4. <u>W-9 (10-2018)</u>	Printed Name of Sig	ning Managing Empl	loyee:			W-9 (10-2018)				
	(0)	5. CP 575/147C (Not req	uired if submitting	a FEDERAL tax exe	mpt letter issu	ed by the IRS)		<u>What is the</u> CP575/147C?				
	ents											
	me	6. IRS Tax Exempt Letter	• • •	nswered Yes to que AL Taxes, submit your	-		sued letter cannot	IRS Tax Exempt Letter for Government				
3:	cn		-	tter must be issued by			sued letter cannot	Agencies				
Section	Do											
ect	uired D	7. Group Attestation for			-		Child Welfare	Long Term Care				
S	uir	Attestation submitted mus provide more than one typ			•	•	High Risk Pregnant	SMI/SED				
	eq		Women & Infants									
	8	8. NPI prinout from the						NPPES Website				
		8. NPT prinout from the	WEPES WEDSILE					INPPES WEDSILE				
		9. <u>SFN 661 (12-2022)</u>	Printed Name of Sig	ning Managing Emp	loyee:			<u>SFN 661 (12-2022)</u>				
		9a. Bank Letter/Vo	oided Check	Must match the Inf	ormation provid	led on the SFN 661						
								Circulified				
		10. <u>SFN 1168 (8-2020)</u>						Simplified Instructions based on				
					<b>a</b> ) ::: I :	<u> </u>		<u>FAQs</u>				
			ing Employees attack									
		10b. List of Board										
		11. <u>SFN 615 (6-2023)</u>	Printed Name of Sig	ning Managing Empl	oyee:			<u>SFN 615 (6-2023)</u>				
		Proof of Insurance is not re provider's responsibility to										
		PROVIDER TYPE	Either 025-Agencies	or 047-Indian Health	Services/638 Tr	ibal						
		SPECIALTY	035-Case Manageme	ent								
		ΤΑΧΟΝΟΜΥ	251B00000X									
	e	Please coordinate w										
	Date	is approved and ar	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									
	Ne	deny. A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a <b>complete</b> application packet is received by the Department. If the date requested is outside the 90 day										
4:	ect	timeframe, the enro		· · · · · · · · · · · · · · · · · · ·	· · · · ·							
ion	Eff	packet was received	1.									
Section	Enrollment Effective	*If this application is assoc complete application pack	-	• • •	•							
	ollo	This application is	associated with an e	mergency service. W	/e are requestin	g the date of	Refer to t	he * above.				
	Eni	Requested Enrollment E	ffective Date									
		Printed Name of Person Requesting the Effective Date				Date						
			lick Here to find mo	re information on	Effective Dates	and Retro Effectiv	ve Date Policies					
		Revision	8/22/2023									

## Group Application Checklist Home Health Agency (HHA) (025 - 082)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

Provider Name  Grganizational NP1#  Service Address  Only 1 service location may be enrolled per Medicaid ID.  Billing Address  Facility Phone  Facility Phone  Contact Person Phone Email  I. 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  Are you Enrolled in Medicare? YES NO YES  Are you exempt from FEDERAL taxes? YES NO YES  Are you exempt from FEDERAL taxes? YES NO YES NO S. How many Managing Employees subtich have 5% or more interest in the enrolling group? YES NO S. How many Managing Employees (authorized to sign on behalf of the business) do you have? Hore the 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (authorized to sign on behalf of the business) do you have? Kenter tha 3Maaging Employees (autho			Application Tracking #							
Billing Address         Mailing Address         Facility Phone         Contact Person         Phone         Email         Image: Address of the second the second of the second of the second the			Provider Name							
Billing Address         Mailing Address         Facility Phone         Contact Person         Phone         Email         Image: Address of the second the second of the second of the second the		ion	Organizational NPI #							
Billing Address         Mailing Address         Facility Phone         Contact Person         Phone         Email         Image: Address of the second		lat								
Billing Address         Mailing Address         Facility Phone         Contact Person         Phone         Email         Image: Address of the second the second of the second of the second the	<del></del>	Dru	Service Address							
Billing Address         Mailing Address         Facility Phone         Contact Person         Phone         Email         Image: Address of the second the second of the second of the second the	on	Infe		Only 1 service locat	ion may be enro	olled per Med	caid ID.			
Facility Phone         Facility Phone         Contact Person         Phone         Email         I. Are you Enrolled in Medicare?         NO         YES         I. Are you Enrolled in Medicare?         NO         YES         I. Are you Enrolled in Medicare?         NO         YES         2. Are you Enrolled in Medicare ID:         Is your Medicare Record up to date?         NO         YES         State Abbv:         Please Provide your Other State Medicaid ID:         3. Are you exempt from FEDERAL taxes?         YES         NO         YES         A. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?         YES         NO         S. How many Managing Employees (authorized to sign on behalf of the business) do you have?         If more than 3 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).         It must contain First Names, Last Names, Dates of Birth, and SNs         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a         YES <td>ecti</td> <td></td> <td>Billing Address</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	ecti		Billing Address							
Contact Person         Phone         Email         I. Are you Enrolled in Medicare?         NO       YES         Is your Medicare Record up to date?         NO       YES         2. Are you Enrolled in Medicaid in another State?       NO         State Abbv:       Please Provide your Other State Medicaid ID:         3. Are you exempt from FEDERAL taxes?       YES         3. Are you exempt from FEDERAL taxes?       YES         YES       NO         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES         5. How many Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       Ist 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	Se	fyii	Mailing Address							
Contact Person         Phone         Email         I. Are you Enrolled in Medicare?         NO       YES         Is your Medicare Record up to date?         NO       YES         2. Are you Enrolled in Medicaid in another State?       NO         State Abbv:       Please Provide your Other State Medicaid ID:         3. Are you exempt from FEDERAL taxes?       YES         3. Are you exempt from FEDERAL taxes?       YES         YES       NO         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES         5. How many Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       Ist 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		enti	Facility Phone							
Phone         Email         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         2. Are you Enrolled in Medicaid in another State?       Please Provide your Other State Medicaid ID:         3. Are you exempt from FEDERAL taxes?       YES       NO       YES         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES       NO         5. How many Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       Ist more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       VES       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       Ga. If Yes, how many Board Members do you have?       NO         If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).       If more than 3 Board Members do you have?       YES       NO         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       YES       NO		q	Contact Person							
Email         I. Are you Enrolled in Medicare?       NO       YES         Please Provide your Medicare ID:       Is your Medicare Record up to date?       NO         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         3. Are you exempt from FEDERAL taxes?       YES       NO         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       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).       Ist 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, 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).       YES       NO         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										
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Is your Medicare Record up to date?       NO       YES         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         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       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).       Ist 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).       NO         18. More than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).       NO       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).       YES       NO         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       NO			1. Are you Enrolled in Me	edicare?		<b>YES</b>	Medicare Enrollme	ent is required		
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         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       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).       Ist 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).       Ist 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       Texture claims			Please Provide y	our Medicare ID:						
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?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       NO       NO         5. How many Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       NO       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       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).       NO         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       NO			Is your Medicare Re	cord up to date?			☐ YES			
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?       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).       NO         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			2. Are you Enrolled in Me	edicaid in another	State?		ΝΟ	VES		
4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES       NO         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       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).       Ist 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?       Ga. If Yes, how many Board Members do you have?       NO         Ga. If Yes, how many Board Members, attach a list as part of Section III of the SFN 1168 (page 2).       If more than 3 Board Members, attach a list as part of Section III of the SFN 1168 (page 2).       NO         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       NO			State Abbv:			Please P	ovide your Other Sta	te Medicaid ID:		
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		S	3. Are you exempt from	FEDERAL taxes?	□ YES		If Exempt from FEDERA	L Taxes, submit you	ur <mark>IRS</mark> issued Tax Exer	npt Letter.
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	tion	estion			es which have	5% or more	interest in the enrollin	ng group?	□ YES	
corporation?       Ga. 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	Sec	Que	If more than 3 Managing Emp	loyees, attach a list as	part of Section I	ll of the SFN 11	• •	ave?		
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				corporation, a no	n-profit corpo	ration, or a g	overnment agency o	rganized as a	☐ YES	
				If more than 3 Board	-	-				
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.)			as the Attending Practitic	oner? (Institutional cl	laims require an d	attending be er	nrolled and entered on clai	ims for processing.	The "attending" can	-
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.
- All Supervisors of case management staff have successfully completed the Department of Human 4. 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).

Street Address City,State, Zip Code

Provider Facility/Organization Name

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** 

Revision Date 4/28/2021

### **GROUP PROVIDER ATTESTATION** TARGETED CASE MANAGEMENT SERVICES LONG TERM CARE

Provider Name (printed)

NPI

Please note that you have requested enrolling as a <u>Case Management</u> 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 <u>NDMedicaidEnrollment@noridian.com</u> 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 <u>Case Management</u> 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. <u>Has the ability to coordinate prenatal care services for individuals, develop relationships</u> 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. <u>Has in place a training process that will ensure that staff have adequate knowledge relating to high-risk pregnancy, parenting and other important issues.</u>
- 5. <u>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.</u>
- 6. <u>Has at least one practitioner who possesses the appropriate training or background as required</u> 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 <u>NDMedicaidEnrollment@noridian.com</u> 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.
- 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<sup>2</sup> 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 ents on	(Month/Day/Year)
Provider Facility Street Address City, State, Zip 0	y/Organization Name 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

<sup>&</sup>lt;sup>2</sup> 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.

		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
		Outdated versions of forms will not be accepted. 1. Coversheet for Fax/Email	Coversheet for	
			Fax/Email	
		2. Group Application Checklist		
		3. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>	
		4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>	
	ents	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	
on 3:	Docum	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:		
Section	ed I	7. CMS Certification Letter		
Š	uire			
	lba	8. Medicare EOB		
	R	9. NPI prinout from the <u>NPPES Website</u>	NPPES Website	
		10. SFN 661 (12-2022)       Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>	
		10a. Bank Letter/Voided Check Must match the Information provided on the SFN 661		
			Simplified	
		11. <u>SFN 1168 (8-2020)</u>	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:	<u>SFN 615 (6-2023)</u>	
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to l		
		PROVIDER TYPE 025-Agencies		
		SPECIALTY 082-Home Health Agency		
		TAXONOMY         251E00000X		
		What is a Taxonomy? Click Here to find more information on Taxonomies		
	Date	Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-ta		
Section 4:	nt Effective	Please coordinate with your billing department and any other applicable area to determ enrollment effective date. <b>The Department will not make changes to that date of</b> <b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more th days* prior to the date a <b>complete</b> application packet is received by the Department. requested is outside the 90 day timeframe, the enrollment effective date assigned will 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 complete application packet is received. You must include a copy of the claim and medical records with your application. This application is associated with an emergency service. We are requesting the date of	an ninety (90) If the date be 90 days	
		Requested Enrollment Effective Date		
		Printed Name of Person		
		Requesting the Date Effective Date		
		Click Here to find more information on Effective Dates and Retro Effective Date Policies		

Revision	

Hospice (025 - 454) Have Questions?

**Group Application Checklist** 

<u>Click Here</u> for FAQs and More Resources

	Application Tracking #							
	Provider Name							
ion	Organizational NPI #							
ion 1: Information								
1: orr	Service Address							
		Only 1 service locati	on may be enrolle	ed per Medica	aid ID.			
ect ng	Billing Address							
Solifyi	Mailing Address							
Sect Identifying	Facility Phone							
Id	Contact Person							
	Phone							
	Email							
	1. Are you Enrolled in Me			<b>YES</b>	Medicare Enrollme	ent is required		
		our Medicare ID:						
	Is your Medicare Re	cord up to date?			☐ YES			
	2. Are you Enrolled in M	edicaid in another	State?			VES		
	State Abbv:			Please Pro	ovide your Other Sta	te Medicaid ID:		
	3. Are you exempt from	FEDERAL taxes?	☐ YES	□ NO	If Exempt from FEDERA	<mark>AL</mark> Taxes, submit you	ur I <mark>RS</mark> issued Tax Exe	mpt Letter.
on 2: tions	4. Do you have any Indivi (Interest may be direct o		s which have 5%	6 or more in	terest in the enrolli	ng group?	□ YES	
Section 2 Question	5. How many Managing B If more than 3 Managing Emp List must contain First Names	oyees, attach a list as	part of Section III o			ave?		
	6. Are you organized as a corporation?	corporation, a nor	n-profit corpora	tion, or a go	overnment agency o	rganized as a	□ YES	
		6a. If Yes, how ma If more than 3 Board SFN 1168 (page 2).	-	-				
	7. What is the name and your claims? <i>(Institutional</i>		-	-			-	
	director or attending/refer	•	-	d on the claii	• •	-	-	
	-							

		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							
		Outdated versions of forms will not be accepted. 1. Coversheet for Fax/Email	Coversheet for								
			Fax/Email								
		2. Group Application Checklist									
		3. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>								
		4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>								
	ments	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								
Section 3:	Docu	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:									
Sec	red	7. CMS Certification (Survey)									
• /	quii	8. Benefit Elect Form									
	Rec	9. NPI prinout from the <u>NPPES Website</u>	NPPES Website								
		10. <u>SFN 661 (12-2022)</u> Printed Name of Signing Managing Employee:	SFN 661 (12-2022)								
		10. <u>SPN 001 (12-2022)</u> Printed Name of Signing Managing Employee. 10a. Bank Letter/Voided Check Must match the Information provided on the SFN 661	<u>SFN 001 (12-2022)</u>								
		11. <u>SFN 1168 (8-2020)</u>	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:	<u>SFN 615 (6-2023)</u>								
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to l									
		PROVIDER TYPE 025-Agencies									
		SPECIALTY       454-Hospice Care, Community Based									
	ate	TAXONOMY         251G00000X           What is a Taxonomy2 Click Hore to find more information on Taxonomics									
		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									
	Effective	<u>Already Know your Taxonomy? Click here to find out which Provider Type &amp; Specialty is assigned to your Taxonomy</u> <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf</u>									
7	ffec	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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 E	enrollment effective date. The Department will not make changes to that date of application is approved and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned will	nce the e enrollment an ninety (90) If the date								
Section	Enrollment E	enrollment effective date. <b>The Department will not make changes to that date of</b> <b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned will 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 day complete application packet is received. You must include a copy of the claim and medical records with your application	nce the e enrollment han ninety (90) If the date be 90 days s prior to the date a ation documents.								
Section	Enrollment E	enrollment effective date. The Department will not make changes to that date of application is approved and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a complete application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned will 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 day complete application packet is received. This application is associated with an emergency service. We are requesting the date of	nce the e enrollment han ninety (90) If the date be 90 days s prior to the date a ation documents.								
Section	Enrollment E	enrollment effective date. <b>The Department will not make changes to that date of application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more th days* prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned wilf 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 day complete application packet is received. You must include a copy of the claim and medical records with your applic This application is associated with an emergency service. We are requesting the date of Requested Enrollment Effective Date	nce the e enrollment han ninety (90) If the date be 90 days s prior to the date a ation documents.								
Section	Enrollment E	enrollment effective date. The Department will not make changes to that date of application is approved and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a complete application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned will 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 day complete application packet is received. This application is associated with an emergency service. We are requesting the date of	nce the e enrollment han ninety (90) If the date be 90 days s prior to the date a ation documents.								

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

# Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #						
	Provider Name						
uo	Organizational NPI #						
nati							
1: orm	Service Address						
on nfc	Billing Address						
Section 1: ying Inforr	Mailing Address						
Section 1: Identifying Information	Facility Phone						
nti							
lde	Contact Person						
	Phone						
	Email						
cion 2: stions	<ol> <li>Are you enrolling any a</li> <li>Are you exempt from F</li> <li>Do you have any Indivi</li> </ol>	If yes, please inclu Provider Type, NP Please note: Service a in the same record as services have been pr FEDERAL taxes?	ude a list with the PI, EIN, and billing ddresses located with out of state service lo ovided at each locat	addresses of all service address). nin North Dakota and border ocations. Out of state service ion.	ing cities (within 50 miles of locations will only be enrol FEDERAL Taxes, submit you	the ND border) canno led in an out of state	ot be enrolled record if
Sectio	(Interest may be direct o	r indirect)					
S O	4. How many Managing E If more than 3 Managing Empl List must contain First Names,	loyees, attach a list as	part of Section III of	-	you have?		
	5. Are you organized as a corporation?	corporation, a no	n-profit corporati	on, or a government ag	ency organized as a	□ YES	
		5a. If Yes, how ma If more than 3 Board SFN 1168 (page 2).	-	ers do you have? ist as part of Section III of th	e		
	6. Will you be providing	ABA (Applied Beha	ivior Analysis) ser	vices?		☐ YES	□ NO
	7. Will you be providing I If yes, Please review the <u>NC</u>			<u>e Services</u> .		☐ YES	□ NO
	I have read and acknowle enrollments) are required etc.) and the individual re must be linked ("affiliate are not actively enrolled application is approved.	d. In order to bill o endering provider, d") to the billing p	n a professional ( /s must be enroll rovider record in	claim form, the billing g ed. Also, the rendering the system. For all rend	roup (clinic, practice, provider's record dering providers who	Enter Initia (required for	

		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						
		Outdated versions of forms will not be accepted. 1. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> Fax/Email							
		2. Group Application Checklist								
		3. List of Service Locations (Required if you answered Yes to question 1 above)								
		4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>							
	nts	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>							
on 3:	Jocume	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	ed D	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.								
S	quire	License # Issued: Expires:								
	Rec	8. NPI prinout from the <u>NPPES Website</u>	NPPES Website							
		9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>							
		9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661								
		10. <u>SFN 9 (5-2021)</u> (Required only if you answered Yes to question 7 above - providing Rehab Services)	<u>SFN 9 (5-2021)</u>							
		11. <u>SFN 1168 (8-2020)</u>	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 b provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required t								
		PROVIDER TYPE 025-Agencies								
		SPECIALTY     397-Local Education (LEA)/Special Education								
		TAXONOMY         251300000X								
	Effective Date	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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.								
Sect	lent	*If this application is associated with an emergency service, the Department may consider a date more than 90 da complete application packet is received. You must include a copy of the claim and medical records with your appl								
	Enrollm	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 Date Effective Date								
	<u>es</u>									

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

	Application Tracking #						
	Provider Name						
uo	Organizational NPI #						
nati		-					
1: Drm	Service Address						
	Billing Address						
Section ying Info	Mailing Address						
Sectidentifying	Facility Phone						
ent							
lde	Contact Person						
	Phone						
	Email						
Section 2: Ouestions	<ul> <li>3. Do you have any Indivi (Interest may be direct o</li> <li>4. How many Managing E</li> <li>If more than 3 Managing Emplication List must contain First Names)</li> </ul>	If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been pr FEDERAL taxes? iduals or Businesse r indirect) Employees (author loyees, attach a list as , Last Names, Dates of corporation, a no 5a. If Yes, how ma	ude a list with the a PI, EIN, and billing a addresses located within a out of state service loc rovided at each locatio PYES es which have 5% o rized to sign on beh part of Section III of th f Birth, and SSNs n-profit corporatio	addresses of all service locat address). In North Dakota and bordering citie cations. Out of state service location. NO If Exempt from FEDER In more interest in the enroll half of the business) do you have SFN 1168 (page 2).	es (within 50 miles of ons will only be enror AL Taxes, submit yo ling group? nave?	f the ND border) canno lled in an out of state	ot be enrolled record if
	6. Will you be providing	ABA (Applied Beha	avior Analysis) serv	ices?		□ YES	
	7. Will you be providing If yes, Please review the <u>N</u>			Services.		☐ YES	□ NO
	enrollments) are require etc.) and the individual r must be linked ("affiliate	d. In order to bill c endering provider ed") to the billing p	on a professional cl /s must be enrolle provider record in t	: Affiliations (separate indiv aim form, the billing group ( d. Also, the rendering provid he system. For all rendering ons should be submitted be	(clinic, practice, der's record ; providers who	Enter Initia (required for (	

		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. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> <u>Fax/Email</u>							
		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:	<u>W-9 (10-2018)</u>							
	1 T	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>							
on 3:	Docume	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	equired [	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:	<u>SFN 661 (12-2022)</u>							
		9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661								
		10. <u>SFN 9 (5-2021)</u> (Required only if you answered Yes to question 7 above - providing Rehab Services)	<u>SFN 9 (5-2021)</u>							
		11. <u>SFN 1168 (8-2020)</u>	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:	<u>SFN 615 (6-2023)</u>							
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to l								
		PROVIDER TYPE 025-Agencies								
		SPECIALTY         397-Local Education (LEA)/Special Education								
		<b>TAXONOMY</b> 251300000X								
Section 4:	Effective Date	<ul> <li>effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (90)</li> <li>days* prior to the date a complete application packet is received by the Department. If the date</li> <li>requested is outside the 90 day timeframe, the enrollment effective date assigned will be 90 days</li> </ul>								
	Enrollment	*If this application is associated with an emergency service, the Department may consider a date more than 90 days complete application packet is received. You must include a copy of the claim and medical records with your application. This application is associated with an emergency service. We are requesting the date of	ation documents.							
	Ш	Requested Enrollment Effective Date								
		Printed Name of Person Requesting the Date Effective Date								
		Click Here to find more information on Effective Dates and Retro Effective Date Policies								
		Revision 8/22/2023								

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# **Group Application Checklist**

Private Duty Nursing (025 - 499)

Have Questions? <u>Click Here</u> for FAQs and More Resources

	Application Tracking #										
	Provider Name										
ion	Organizational NPI #										
lat											
Section 1: ying Information	Service Address										
on Infc	Billing Address										
	Mailing Address										
Sect Identifying	Facility Phone										
enti											
Ide	Contact Person										
	Phone										
	Email										
	1. Are you Enrolled in Me			VES							
	Please Provide y Is your Medicare Re	our Medicare ID:				YES					
	is your wedicare ke	cord up to date:				163					_
	2. Are you Enrolled in Me	edicaid in another	State?			NO	YES				
	State Abbv:			Please Pr	ovide you	r Other Sta	te Medicaid ID:				
Section 2: Questions		If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been pr	PI, EIN, and b ddresses locate out of state se	illing address). ed within North Do rvice locations. Ou	akota and b	ordering citie	s (within 50 miles of	the ND l	border) cann	ot be enro	olled
Section Questio	4. Are you an Out of State	e Provider (Service	location mo	ore than 50 mil	es from t	he North Da	akota		YES		NO
Sei Qu	border?) If yes, a copy of	f the claim for the	service that	was provided	to an elig	ible ND Me	dicaid Recipient	must k		ted with	
	your enrollmer	nt documents. The	date of serv	ice on the clair	n must su	pport your	requested effec	tive da	te for enro	ollment.	
	5. Are you exempt from	FEDERAL taxes?	□ YES		If Exemp	t from FEDER	AL Taxes, submit yo	ur <mark>IRS</mark> iss	sued Tax Exe	empt Lette	er.
	6. Do you have any Indivi	iduals or Pusinoss	a which have	o E% or more	intoract ir	the enroll					
	(Interest may be direct o				interest ii	i the emon			YES		NO
	7. How many Managing E If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section	n III of the SFN 11			ave?				
	8. Are you organized as a	corporation, a no	n-profit corp	oration, or a g	overnme	nt agency o	rganized as a		YES		NO
	corporation?	8a. If Yes, how m If more than 3 Board SFN 1168 (page 2).	-	-		of the					
	I have read and acknowle enrollments) are required etc.) and the individual re must be linked ("affiliate are not actively enrolled application is approved.	edge that I unders d. In order to bill o endering provider d") to the billing p	on a professio /s must be e provider reco	onal claim form nrolled. Also, and in the syste	n, the bill the rende m. For all	ing group (« ering provid I rendering	clinic, practice, er's record providers who	(re	Enter Initi quired for		

The documents requested below must be returned to the Department in order to process your	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. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> <u>Fax/Email</u>							
2. Group Application Checklist								
3. List of Service Locations (Required if you answered Yes to question 3 above)								
4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>							
5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>							
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 iss	ssued letter <u>for Government</u> <u>Agencies</u>							
Connot be substituted. The letter must be issued by the IRS.          7. RN/LPN License. License must be from one of your rendering RN/LPN practitioners, must configuration of the expired.         Image: state below, and must not be expired.	over the							
License # Issued: Expires:								
8. NPI prinout from the <u>NPPES Website</u>	NPPES Website							
9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>							
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 Purpose	es Only							
11. <u>SFN 1168 (8-2020)</u>	Simplified Instructions based on							
	<u>FAQs</u>							
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:	<u>SFN 615 (6-2023)</u>							
Proof of Insurance is not required for any application. If proof of insurance is submitted with an application provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not								
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. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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 complete application packet is received. You must include a copy of the claim and medical records with This application is associated with an emergency service. We are requesting the date of	h your application documents.							
	Refer to the * above.							
Requested Enrollment Effective Date           Printed Name of Person								
Requesting the Date Date								
Click Here to find more information on Effective Dates and Retro Effective D	Date Policies							

# **Group Application Checklist**

General Ambulatory Health Care Facility (026)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #								
	Provider Name								
Section 1: dentifying Information	Organizational NPI #								
1: orma	Service Address								
ion Infe	Billing Address								
Section ying Info	Mailing Address								
S( tifyi	Facility Phone								
den	Contact Person								
	Phone								
	Email								
	1. Are you Enrolled in Me Please Provide y Is your Medicare Re	our Medicare ID:		) YES	YES				
	2. Are you Enrolled in Me	edicaid in another			NO	YES			
	State Abbv:		F	Please Provide yo	our Other Sta	te Medicaid ID:			
Section 2: Questions	4. Are you an Out of State	Provider Type, NF Please note: Service a in the same record as services have been p Provider (Service	rovided at each locati	address). in North Dakota and cations. Out of state on. an 50 miles from	bordering citie e service location the North D	s (within 50 miles of ons will only be enro akota	the ND border) cann lled in an out of state	oot be enrol e record if	led NO
	If yes, a copy of	f the claim for the nt documents. The							
	5. Are you exempt from	FEDERAL taxes?	Sector YES	<b>NO</b> If Exem	pt from FEDER	AL Taxes, submit yo	ur I <mark>RS</mark> issued Tax Exe	mpt Letter.	
	6. Are you providing Mee	dicare Diabetes Pr	evention Program	(MDPP) Service	;?		□ YES		NO
	7. Do you have any Indivi (Interest may be direct o		es which have 5% o	or more interest	in the enroll	ing group?	□ YES		NO
	8. How many Managing E If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section III of t			ave?			
	9. Are you organized as a corporation?	corporation, a no	n-profit corporatio	on, or a governm	ent agency o	rganized as a	□ YES		NO
		•	any Board Membe Members, attach a lis	•	III of the				
	I have read and acknowle enrollments) are required etc.) and the individual re must be linked ("affiliate are not actively enrolled application is approved.	d. In order to bill o endering provider d") to the billing p	n a professional c /s must be enrolle rovider record in t	aim form, the bi d. Also, the rend the system. For a	lling group ( lering provid Ill rendering	clinic, practice, ler's record providers who	Enter Initi (required for		

		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				
		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. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>					
	ents	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>					
on 3:	ocum	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					
Section	ed D	7. License. License must be from one of your rendering MD practitioners, must cover the effective date below, and must not be expired.						
S	luire	License # Issued: Expires:						
	Req	8. <u>PCP Questionnaire</u> Required for the following Specialties: 503-Single Specialty (193400000X) 359-Clinic/Center (261Q00000X)	PCP Questionnaire					
		9. NPI prinout from the <u>NPPES Website</u>	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						
		11. Claim (Nequired in you answered res to question 4 above) claims submitted are for emoliment purposes only	Simplified					
		12. <u>SFN 1168 (8-2020)</u>	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. <u>SFN 615 (6-2023)</u> 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 provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to l						
		PROVIDER TYPE         026- Ambulatory Health Care Facilities						
		SPECIALTY						
	Date	ΤΑΧΟΝΟΜΥ						
		What is a Taxonomy? Click Here to find more information on Taxonomies						
	tive	<u>Already Know your Taxonomy? Click here to find out which Provider Type &amp; Specialty is assigned to y</u> <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-tax</u>						
Section 4:	Enrollment Effective	Please coordinate with your billing department and any other applicable area to determ enrollment effective date. <b>The Department will not make changes to that date of</b> <b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more th days* prior to the date a <b>complete</b> application packet is received by the Department. requested is outside the 90 day timeframe, the enrollment effective date assigned will from the date the complete application packet was received.	n <b>ce the</b> enrollment an ninety (90) If the date					
	my &	*If this application is associated with an emergency service, the Department may consider a date more than 90 days complete application packet is received. You must include a copy of the claim and medical records with your application						
	Taxonomy	This application is associated with an emergency service. We are requesting the date of	Refer to the * above.					
	Та	Requested Enrollment Effective Date						
		Printed Name of Person Requesting the Date Effective Date						
		Click Here to find more information on Effective Dates and Retro Effective Date Policies						

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

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #						
		Provider Name						
	ion	Organizational NPI #						
	Jat							
÷	nn	Service Address						
No	Info	Billing Address						
Section	20 U	Mailing Address						
Š	Identifying Information	Facility Phone						
	ent							
	Ide	Contact Person						
		Phone						
		Email						
	S		If yes, please inclu Provider Type, NF Please note: Service a in the same record as	ude a list with the ad PI, EIN, and billing ad addresses located within I	dresses of all service locat dress). North Dakota and bordering citic tions. Out of state service locatio	es (within 50 miles of t	he ND border) cannot	be enrolled
n 2	<b>N</b> O	2. Are you exempt from F	EDERAL taxes?		If Exempt from FEDER	AL Taxes, submit your	IRS issued Tax Exem	pt Letter.
Section	Questi	3. Do you have any Indivi (Interest may be direct or		es which have 5% or	more interest in the enroll	ling group?	□ YES	□ NO
		4. How many Managing E If more than 3 Managing Emp List must contain First Names,	loyees, attach a list as	s part of Section III of the	If of the business) do you l SFN 1168 (page 2).	have?		
		5. Are you organized as a corporation?	•		, or a government agency (	organized as a	☐ YES	□ NO
				any Board Members Members, attach a list a	do you have? s part of Section III of the			
		enrollments) are required etc.) and the individual re must be linked ("affiliate	d. In order to bill c endering provider d") to the billing p	on a professional clai /s must be enrolled. provider record in the	Affiliations (separate indiv m form, the billing group ( Also, the rendering provide system. For all rendering as should be submitted be	(clinic, practice, der's record ; providers who	Enter Initial (required for e	

Protect ensure you use the binks provided to obtain the current versions of each form.         Height Links         Submittee           1. Coversheet for Fax/Email			The documents requested below must be returned to the Department in order to process your enrollment							
1-OutStratet for PNALTING       For final         2. Group Application Checklist				Helpful Links	Submitted					
2. List of Service Locations (Required if you answered Yes to question 1 above)			1. <u>Coversheet for Fax/Email</u>							
A <u>WP 110-2018</u> Finited Name of Signing Managing Employee:     WP 2110-2018     Sc P 575/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/61/12-2022     File SetEletee I 100-1000     C 975/47C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     C 975/61/12-2022     File SetEletee I 100-1000     File SetEleteeEletee I 10000     File SetEletee I 100-1000			2. Group Application Checklist							
S. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)     Vitat is the     Vitat     Vitat			3. List of Service Locations (Required if you answered Yes to question 1 above)							
01000       0100000000000000000000000000000000000			4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>						
Berger 2000     Berger 20000     Berger 2000     Berger 20000     Berger 200000     Berger 20000     Berger 200000     Berger 200000     Berger 200000     Berger 200000     Berger2		nts	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)							
Theores: License must be from one of your rendering practitioners, must cover the effective date       Image: Cover and must not be expired.         Internet: Cover and must not be expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Strip Cover and must not be expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Strip Cover and must not be expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Strip Cover and must not be expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Strip Cover and must not be expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Strip Cover and the expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Strip Cover and the expired.       Image: Cover and must not be expired.       Image: Cover and must not be expired.         Instruction the file the cover and the expired in the spired.       Image: Cover and the expired in the expired in the file the remains the provider responsibility to ensure that the necksary instance in the provider regulation.       Image: Cover and provide in the file the remains the provider regulation.         PROVIDER TYPE       O26-Ambulatory Healt Care Facilities       SEECALTY       O26-Ambulatory Healt Care Facilities         SEECALTY       O26-Ambulatory Healt Care Facilities	on 3:	υ.	If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter	for Government						
Image: space of the space	Secti	red D								
8. NPI printout from the NPPES Website     NPPES Website     SEN 661 (12:2022)     Printed Name of Signing Managing Employee:     SEN 661 (12:2022)     Printed Name of Signing Managing Employee:     SEN 661 (12:2022)     Sen 661 (12:2022	• /	int	License # Issued: Expires:							
9a. Bank Letter/Voided Check       Must match the Information provided on the SFN 661       Image: Control of Control Contecont Contecont Control Control Control Control Conten		U U	8. NPI printout from the <u>NPPES Website</u>	NPPES Website						
9a. Bank Letter/Voided Check       Must match the Information provided on the SFN 661       Image: Control of Control Contecont Contecont Control Control Control Control Conten										
10. SFN 1168 (8-2020)       Instructions based on FAGs         10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs       Imstructions based on FAGs         10b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.       Imstructions based on FAGs         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 up hore to the submitted with an application, it will be deleted from the flie. It remains the provider's responsibility on ensure that the necessary insurance is is place, but proof of insurance is not required to be submitted for any application.         PROVIDER TYPE       026-Adolescent and Children Mental Health         TAXONOMY       2610M0855X         What Is a Taxonomy? Click Here to find more information on Taxonomies         Alterady Knowyour Taxonomy? Click Here to find out which Provider Type & Specialty is assigned to your Taxonomy https://www.hhs.nd.av/siles/www/files/documents/DH5%20Legacy/nmis-group-provider-code-taxonomy.pdf         Please coordinate with your Dilling 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 date a complete application packet is 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.       Nef			9. <u>SFN 661 (12-2022)</u> Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>						
10. SFN 1168 (6-2020)       Instructions based on FAQs         10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs       Image: Control of SNs (Control o			9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661							
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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.         PROVIDER TYPE       0.26-Ambulatory Health Care Facilities         SPECIALTY       0.26-Andbulatory Health Care Facilities         Value Automation of Taxonomies       Material Health         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/DH5%20Legacv/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 a complete application packet is received by the Department. If the date requested is outside the 90 days from the date the complete application packet was received.         *If this application is associated with an emergency service. We are requesting the date of			10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs							
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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       0.26-Ambulatory Health Care Facilities         SPECIALTY       0.26-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/DH5%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. We are requesting the date of					remains the					
PECIALTY       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/DH5%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										
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.         Image: This application is associated with an emergency service. We are requesting the date of			PROVIDER TYPE     026- Ambulatory Health Care Facilities							
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/DH5%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. Service with your application documents.         This application is associated with an emergency service. We are requesting the date of			SPECIALTY 026-Adolescent and Children Mental Health							
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 was received.         Requested Enrollment Effective Date         Printed Name of Person Requesting the Effective Date       Date         Printed Name of Person Requesting the Effective Date       Date         Click Here to find more information on Effective Dates and Retro Effective Date Policies       Date Policies			TAXONOMY         261QM0855X							
Inttps://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.         Image: 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 Dates and Retro Effective Date Policies			What is a Taxonomy? Click Here to find more information on Taxonomies							
Please coordinate with your billing department and any other applicable area to determine the correct 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. 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		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 <b>complete</b> 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 Effective Date Date		Dat	https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-taxonomy.pdf							
*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	Section 4: ent Effective	ent Effective	enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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							
Requested Enrollment Effective Date   Printed Name of Person   Requesting the   Effective Date	nroll		complete application packet is received. You must include a copy of the claim and medical records with your application	ation documents.						
Printed Name of Person Requesting the Effective Date Click Here to find more information on Effective Dates and Retro Effective Date Policies										
Requesting the Effective Date     Date       Click Here to find more information on Effective Dates and Retro Effective Date Policies										
			Effective Date							

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# **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. <u>Click Here</u> 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	

	Application Tracking #										
_	Provider Name										
Section 1: Identifying Information	Organizational NPI #										
1: Drm:	Service Address										
on (	Billing Address										
Section ying Inf	Mailing Address										
Seifyin	Facility Phone										
ent											
Id	Contact Person										
	Phone										
	Email										
	1										
	1. Are you Enrolled in Me			VES							
	Please Provide y Is your Medicare Re	your Medicare ID:		□ <b>NO</b>	□ YES						
											_
	2. Are you Enrolled in Medicaid in another State?										
	State Abbv:			Please Pro	vide your Ot	her Sta	te Medicaid ID:				
Section 2: Questions	<ul> <li>3. Are you enrolling any a</li> <li>4. Are you an Out of State border?)</li> <li>If yes, a copy of</li> </ul>	If yes, please inclu Provider Type, NP Please note: Service and in the same record as services have been pr	Ide a list with I, EIN, and bil ddresses located out of state serv ovided at each lo location mor	the addresses ling address). within North Dak ice locations. Out ocation. e than 50 mile	of all service ota and border of state service s from the N	ing cities location orth Da	s (within 50 miles of ns will only be enrol akota	f the ND l led in an	border) cann out of state YES	oot be enro record if	NO
		nt documents. The									
	5. Are you exempt from	FEDERAL taxes?	YES		If Exempt from	n FEDER/	AL Taxes, submit yo	ur <mark>IRS</mark> iss	sued Tax Exe	empt Lette	er.
	6. Do you have any Indivi (Interest may be direct o		es which have	5% or more in	terest in the	enrolli	ing group?		YES		NO
	7. How many Managing E If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section	III of the SFN 1168	-	o you h	ave?				
	8. Are you organized as a corporation?	corporation, a nor	n-profit corpo	oration, or a go	vernment ag	gency o	rganized as a		YES		NO
		8a. If Yes, how ma If more than 3 Board SFN 1168 (page 2).	•	-		e					
	9. What is the name and (Institutional claims require attending/referring doctor. Name:	e an attending be en	nrolled and ent	ered on claims f claim, or the att	or processing	. The "d enrolle	attending" can be	e either	-		

		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. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> Fax/Email						
		2. Group Application Checklist							
		3. List of Service Locations (Required if you answered Yes to question 3 above)							
		4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>						
	nts	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the <u>CP575/147C?</u>						
on 3:	ocume	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						
Section	uired D	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:							
	eq	8. NPI prinout from the <u>NPPES Website</u>							
	8	8. NPI prinout from the <u>NPPES Website</u>	<u>NPPES Website</u>						
		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. <u>SFN 1168 (8-2020)</u>	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. <u>SFN 615 (6-2023)</u> Printed Name of Signing Managing Employee:	<u>SFN 615 (6-2023)</u>						
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be of provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to b							
		PROVIDER TYPE 026- Ambulatory Health Care Facilities							
		SPECIALTY 089-Ambulatory Surgical Center							
		<b>TAXONOMY</b> 261QA1903X							
Section 4:	Effective Date	Please coordinate with your billing department and any other applicable area to determ enrollment effective date. <b>The Department will not make changes to that date of</b> <b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more th days** prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned will from the date the complete application packet was received.	nce the e enrollment an ninety (90) t. If the date						
Sect	rollment	**If this application is associated with an emergency service, the Department may consider a date more than 90 day complete application packet is received. You must include a copy of the claim and medical records with your appli							
	Enro	This application is associated with an emergency service. We are requesting the date of F	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. <u>Click Here</u> for the ASC institutional checklist.

Have Questions?
<b><u>Click Here</u></b> for FAQs and More Resources

	Application Tracking #						
	Provider Name						
ion 1: Information	Organizational NPI #						
nat							
1: orn	Service Address						
ion Inf	Billing Address						
Section ying Info	Mailing Address						
Sect	Facility Phone						
sht							
Ide	Contact Person						
	Phone						
	Email						
	1. Are you an Out of Stat border?)	e Provider (Servic	e location more th	aan 50 miles from the North	n Dakota	🗌 YES	□ NO
Section 2: Questions	<ul> <li>2. Are you enrolling any additional service locations not listed above at this time?</li> <li>YES</li> <li>NO</li> <li>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).</li> <li>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.</li> <li>3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota</li> </ul>						
SO			-	provided to an eligible ND N the claim must support you	-		
	4. Are you exempt from	FEDERAL taxes?	S YES	<b>NO</b> If Exempt from FEDE	RAL Taxes, submit yo	ur I <mark>RS</mark> issued Tax Exe	mpt Letter.
	5. Do you have any Indiv (Interest may be direct o		es which have 5%	or more interest in the enro	lling group?	☐ YES	
	6. How many Managing I If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section III of t	half of the business) do you he SFN 1168 (page 2).	have?		
	7. Are you organized as a corporation?	· ·		on, or a government agency	organized as a	□ YES	🗌 NO
		7a. If Yes, how ma If more than 3 Board SFN 1168 (page 2).	-	rs do you have? t as part of Section III of the			
	enrollments) are require etc.) and the individual r must be linked ("affiliate	ed. In order to bill o rendering provider ed") to the billing p	on a professional o /s must be enrolle provider record in	g: Affiliations (separate indi laim form, the billing group ed. Also, the rendering prov the system. For all renderin ions should be submitted b	) (clinic, practice, rider's record ng providers who		ials below r enrollment)

	<b>The design of the second se</b>	d h al ann an an h a matrice a d ta tha	Deventurent	••••••••••••••••••••••••••••••••••••••						
	The documents requeste Please ensure you use th									
	Outdated versions of for					Helpful Links	Submitted			
	1. Coversheet for Fax/Em	nail				Coversheet for Fax/Email				
	2. Group Application Che	ecklist								
	3. List of Service Locations (Required if you answered Yes to question 2 above)									
	S. List of Service Location	is (Required if you answered fe	s to question 2							
	4. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing	g Employee:			<u>W-9 (10-2018)</u>				
ents	5. CP 575/147C (Not requ	uired if submitting a FEDERAL tax	x exempt lette	r issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>				
3: um	6. IRS Tax Exempt Letter	(Required if you answered Yes to If Exempt from FEDERAL Taxes, submit cannot be substituted. The letter mus	t your IRS issued	Tax Exempt Letter. A St	ate issued letter	IRS Tax Exempt Letter for Government Agencies				
Section ired Doc	7. License. License must l below, and must not be	be from one of your rendering N expired.	1D practitione	rs, must cover the e	ffective date					
S quir	License #	•		Expires:						
Rec	8. NPI prinout from the N	IPPES Website				NPPES Website				
	9. SFN 661 (12-2022)	Printed Name of Signing Managing	g Employee:			SFN 661 (12-2022)				
	9a. Bank Letter/Vo			provided on the SFN 6	561					
	10. Claim (Required if yo	u answered Yes to question 3 ab	ove) <mark>Claims sub</mark> i	mitted are for Enrollme	ent Purposes Only					
	11. <u>SFN 1168 (8-2020)</u>					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 M	embers attached to Section III (Pag	e 2) with dates	of birth and SSNs.						
	12. SFN 615 (6-2023)	Printed Name of Signing Managing	g Employee:			<u>SFN 615 (6-2023)</u>				
		equired for any application. If proof o ensure that the necessary insurance								
	PROVIDER TYPE	026- Ambulatory F	lealth Care Fac	cilities						
ate	SPECIALTY/Taxonomy (Please Choose One)	503-Single Specialty 193400000X		llti-Specialty 200000X						
: Effective D	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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		ciated with an emergency service, t et is received. You must include a c associated with an emergency serv	opy of the claim	and medical records	s with your applic					
کر ھ				acoung the date of _	·					
non	Requested Enrollment Ef Printed Name of Person	fective Date					1			
axonomy	Requesting the Effective Date			Date						
E E		Here to find more information of	n Effective Dat	es and Retro Effect	ive Date Policie	<u>s</u>				
	Revision	8/22/2023					-			

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#### Group Application Checklist Dental Group (026)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

Application Tracking #									
Provider Name									
O Organizational NPI #									
Service Address									
Billing Address									
Billing Address       Mailing Address       Facility Phone									
Organizational NPI # Service Address Billing Address Mailing Address Facility Phone Contact Person									
Contact Person									
Phone									
Email									
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 o									
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?) If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipient must be your enrollment documents. The date of service on the claim must support your requested effective date	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.									
	for enronment.								
3. Are you exempt from FEDERAL taxes? YES INO If Exempt from FEDERAL Taxes, submit your IRS issue	d Tax Exempt Letter.								
4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?	YES 🗌 NO								
(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	YES 🗌 NO								
corporation?									
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	nter Initials below								
	lired for enrollment)								
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									

The documents request	ed below must be returned to the	P Department in order to process	vour enrollment							
Please ensure you use the	he links provided to obtain the cu		, car chronnent	Helpful Links	Submitted					
				Coversheet for						
1. Coversneet for Pax/El				Fax/Email						
2. Group Application Checklist										
3. List of Service Locations (Required if you answered Yes to question 1 above)										
A W/ 9 (10 2018)	Printed Name of Signing Managing			W 9 (10 2018)						
4. <u>W-5 (10-2018)</u>				<u>W-9 (10-2018)</u>						
5. CP 575/147C (Not req	uired if submitting a FEDERAL ta	x exempt letter issued by the IRS	)	<u>What is the</u> <u>CP575/147C?</u>						
6. IRS Tax Exempt Letter		IRS Tax Exempt Letter								
	If Exempt from FEDERAL Taxes, submi	t your I <mark>RS</mark> issued Tax Exempt Letter. A S	tate issued letter	for Government Agencies						
7. License. License must	be from one of your MD practitio	oners, must cover the effective d	ate below, and							
must not be expired.	t Issued	Evniros								
	issued:	Expires.								
8. NPI prinout from the	NPPES Website			<u>NPPES Website</u>						
9. <u>SFN 661 (12-2022)</u>	Printed Name of Signing Managing	g Employee:		<u>SFN 661 (12-2022)</u>						
9a. Bank Letter/Vo	bided Check Must match th	e Information provided on the SFN	661							
11. <u>SFN 1168 (8-2020</u> )		Simplified Instructions based on FAOs	1							
11a. List of Managir	ng Employees attached to Section III	(Page 2) with dates of birth and SSN	ls	11100						
11b. List of Board N										
12. SFN 615 (6-2023)	Printed Name of Signing Managing	; Employee:		SFN 615 (6-2023)						
	equired for any application. If proof	of insurance is submitted with an ap	plication, it will be o	deleted from the file. I	t remains the					
· · · · · · ·			is not required to b	e submitted for any a	pplication.					
			-							
(Please Choose One)	437-Dental Clinic 261QD0000X	503-Single Specialty 193400000X								
Please coordinate w	ith your billing department	and any other applicable a	+ rea to determ	ine the correct	7					
enrollment effective	date. The Department w	vill not make changes to	that date on	ice the						
days* prior to the d	ate a complete application	n packet is received by the	Department.	If the date						
requested is outside from the date the co	e the 90 day timeframe, the omplete application packet	e enrollment effective date was received.	assigned will	be 90 days						
					-					
		• •	•	•						
			_	· · · · · ·						
This application is	s associated with an emergency serv	ice. We are requesting the date of _	R	eter to the * above.						
Requested Enrollment E	ffective Date									
		Data			]					
Effective Date					1					
<u>Click</u> Revision	Here to find more information of 8/22/2023	n Effective Dates and Retro Effect	tive Date Policies							
	Please ensure you use the Outdated versions of for 1.         Outdated versions of for 1.         Coversheet for Fax/Er         2. Group Application Ch         3. List of Service Location         4. W-9 (10-2018)         5. CP 575/147C (Not required)         6. IRS Tax Exempt Letter         7. License. License must must not be expired.         License 1         8. NPI prinout from the         9. SFN 661 (12-2022)         9a. Bank Letter/Vo         10. Claim (Required if yother in the interned)         11. SFN 1168 (8-2020)         11a. List of Managing         11b. List of Board W         Proof of Insurance is not reprovider's responsibility to the days* prior to the days* prior to the days* prior to the days application is associate of the days* prior to the days application is associate of the days application is associate of the date the complete application pack         This application is associate of the days application is associate of the date the complete application pack         This application is associate of the days application is associate of the date the complete application pack         Complete application is associate of the date the complete application pack         Click         *If this application is associate of the date the complete application pack         Click         *If this application is associate of the date the complete application pac	Please ensure you use the links provided to obtain the cu Outdated versions of forms will not be accepted.         1. Coversheet for Fax/Email         2. Group Application Checklist         3. List of Service Locations (Required if you answered Yest         4. W-9 (10-2018)       Printed Name of Signing Managing         5. CP 575/147C (Not required if submitting a FEDERAL tax         6. IRS Tax Exempt Letter (Required if you answered Yest         7. License. License must be from one of your MD practition         must not be expired.         License #         1 Essued:         8. NPI prinout from the NPPES Website         9. SFN 661 (12-2022)         Printed Name of Signing Managing         9. SFN 661 (12-2022)         Printed Name of Signing Managing         9. SFN 661 (12-2022)         Printed Name of Signing Managing         9. SFN 661 (12-2022)         Printed Name of Signing Managing         9. SFN 661 (12-2022)         Printed Name of Signing Managing         9. SFN 661 (12-2023)         Printed Name of Signing Managing         10. Claim (Required if you answered Yes to question 2 ab         11. SFN 1168 (8-2020)         11. SFN 1168 (8-2023)         Printed Name of Signing Managing         Provider's responsibility to ensure that the necessary insuranc	Please ensure you use the links provided to obtain the current versions of each form.         Outdated versions of forms will not be accepted.         1. 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:         5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS         6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above)         If Exempt from FEDERAL Taxes, submity your IRS issued Tax Exempt Letter. AS cannot be substituted. The letter must be issued by the IRS.         7. License. License must be from one of your MD practitioners, must cover the effective d must not be expired.         License #       Issued:       Expires:         8. NPI prinout from the NPPES Website       9. SFN 661 (12-2022)       Printed Name of Signing Managing Employee:         9. a Bank Letter/Volded Check       Must match the Information provided on the SFN         10. Claim (Required if you answered Yes to question 2 above) Claims submitted are for Enrollment 11. SFN 1168 (8-2020)       11. stint dist of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs.         12. SFN 615 (6-2023)       Printed Name of Signing Managing Employee:       Proof of Insurance is not required for any application. If proof of Insurance is submitted with an ap provider's responsibility to ensure that the eccesary insurance is	Please ensure you use the links provided to obtain the current versions of each form.         Outdated versions of forms will not be accepted.         1. Coversheet for Fax/Email         2. Group Application Checklist         3. List of Service Locations (Required if you answered Yes to question 1 above)         4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:         5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)         6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Teampt from FEDERAL Taxe, submit your ITS issued Tax Exempt Letter. A State issued letter commot work instituted. The Net must be issued by the IRS.         7. Leanse. Leanse must be from one of your MD practitioners, must cover the effective date below, and must not be expired.         9. SEN 651 (12-2022)       Printed Name of Signing Managing Employee:         9. SEN 651 (12-2022)       Printed Name of Signing Managing Employee:         9. SEN 651 (12-2022)       Intel Name of Signing Managing Employee:         9. SEN 651 (12-2022)       Intel Name of Signing Managing Employee:         9. SEN 651 (12-2022)       Intel Name of Signing Managing Employee:         11. SEN 1168 (8-2020)       Intel Name of Signing Managing Employee:         12. SEN 615 (5-2023)       Printed Name of Signing Managing Employee:         Proof Invarance is not required to any application It proof of invarance is not required to SNs.         11	Outdated versions of forms will not be accepted.         Heippul Links           1. Coversheet for Fax/Email         Goversheet for Fax/Email         Goversheet for Fax/Email           2. Group Application Checklist         Image: Checklist         Image: Checklist           3. List of Service Locations (Required if you answered Yes to question 1 above)         Image: Checklist         Image: Checklist           4. W.9 (10:2018)         Printed Name of Signing Managing Employee:         W-9 (10:2018)         What is the CPSE/FAYC?           6. IRS Tax Exempt Letter (Required if you answered Yes to question 3 above) If Kempt For IRCDEAL Taxes, Jubrit your RS based Tax Exempt Letter. A State issued tetter if Covernment Cammote brabatitick. The letter must be issued by the IRS.         INS Tax Exempt Letter if Covernment Accenter           7. License, License must be from one of your MD practitioners, must cover the effective date below, and License #         INPPES Website         NPPES Website           8. NPI prinout from the NEPES Website         NPPES Website         SFIN 661 (12:2022)         SFIN 661 (12:2022)           9. Bank Letter/Voided Check         Must match the Information provided on the SFIN 661         Immutation based on FAG3           11. SFIN 1166 (8:2020)         Immutation the accepterial in the data of Signing Managing Employee:         SFIN 661 (12:2022)           9. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs         Immutation based on FAG3           11. SFIN					

#### 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	Questi	ons?	
-	_		

#### **<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #									
		Provider Name									
	Information	Organizational NPI #									
	Jat										
1:	Drm	Service Address									
uc	nfc		Only 1 service locat	ion may be enrol	lled per Medio	caid ID.					
		Billing Address									
Se	f <u></u>	Mailing Address									
	Identifying	Facility Phone									
	lde	Contact Person									
		Phone									
		Email									
								1			
		1. Are you Enrolled in Me			VES	Medicare Enrollme	ent is required				
		Please Provide y	your Medicare ID:								
		Is your Medicare Re	cord up to date?			□ YES					
							_				
		2. Are you an Out of Stat	e Provider (Service	e location more	e than 50 mi	les from the North D	akota		YES		NO
		border?) If yes, a copy o	f the claim for the	service that wa	as provided	to an eligible ND Me	edicaid Recipient	t must k	oe submiti	ted with	
					•	m must support your					
2:	SC					7					
	D	3. Are you exempt from	FEDERAL taxes?	S YES		If Exempt from FEDERA	AL Taxes, submit you	ur <mark>IRS</mark> iss	ued Tax Exe	mpt Lette	r.
tio	estio	4. Do you have any Indivi	duals or Businesse	s which have 5	% or more i	nterest in the enrolli	ing group?				
Section	Jue	(Interest may be direct o							YES		NO
S	0										
		5. How many Managing		-			lave?				
		If more than 3 Managing Emp List must contain First Names	-	-	I OI THE SEN II	68 (page 2).					
			_		-						
		6. Are you organized as a corporation?	corporation, a no	n-profit corpor	ation, or a g	overnment agency o	rganized as a		YES		NO
			6a. If Yes, how ma	•	-						
			If more than 3 Board SFN 1168 (page 2).	wempers, attach	a list as part o	Section III of the					

		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. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> <u>Fax/Email</u>								
		2. Group Application Checklist									
		3. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>								
		4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>								
	ments	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								
Section 3:	Do	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:									
Sec	ired										
	nb	7. CMS Certification Letter									
	Re	8. NPI prinout from the <u>NPPES Website</u>	NPPES Website								
		9. <u>SFN 661 (12-2022)</u> Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>								
		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									
			Simplified								
		11. <u>SFN 1168 (8-2020)</u>	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:	<u>SFN 615 (6-2023)</u>								
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be									
		provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to <b>PROVIDER TYPE</b> 026- Ambulatory Health Care Facilities	be submitted for any ap	plication.							
		PROVIDER TYPE       026- Ambulatory Health Care Facilities         SPECIALTY       361-Federally Qualified Health Center									
	ate	TAXONOMY 261QF0400X									
	lment Effective Da	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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:	& Enrollr	**If this application is associated with an emergency service, the Department may consider a date more than 90 d complete application packet is received. You must include a copy of the claim and medical records with your appl This application is associated with an emergency service. We are requesting the date of	• •								
	h	Requested Enrollment Effective Date									
	axono	Printed Name of Person Requesting the Date									
	Tax	Effective Date									
	•	Click Here to find more information on Effective Dates and Retro Effective Date Policie	<u>!S</u>								
		Revision 8/22/2023									

## 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 <u>regular FQHC checklist</u> with taxonomy 261QF0400X.

#### Have Questions? <u>Click Here</u> for FAQs and More Resources

		Application Tracking #								
		Provider Name								
	ion	Organizational NPI #								
	lat									
;;	Drm	Service Address								
on	Info	Billing Address								
Section	ല്ല	Mailing Address								
	dentifying Information	Facility Phone								
	ent									
	Ide	Contact Person								
		Phone								
		Email								
on 2:	estions		If yes, please inclu Provider Type, NF Please note: Service a in the same record as	ude a list with the addro PI, EIN, and billing addro ddresses located within Nor	esses of all service locati	es (within 50 miles o	f the ND	border) canno	t be enr	
Section	Que		the claim for the	service that was provid	miles from the North Da ed to an eligible ND Mea laim must support your	dicaid Recipient				NO
		3. Are you exempt from	FEDERAL taxes?		If Exempt from FEDER	<mark>AL</mark> Taxes, submit yo	ur <mark>IRS</mark> iss	ued Tax Exem	pt Lette	r.
		4. Do you have any Indivi (Interest may be direct o		es which have 5% or mo	ore interest in the enroll	ing group?		YES		NO
		5. How many Managing E If more than 3 Managing Emp List must contain First Names,	loyees, attach a list as	part of Section III of the SFI	• •	ave?				
		6. Are you organized as a corporation?	corporation, a nor	n-profit corporation, or	a government agency o	rganized as a		YES		NO
				Iny Board Members do Members, attach a list as pa						

	The documents requeste	d below must be returned to the	e Department i	n order to process	your enrollmen	t			
	· · · · · · · · · · · · · · · · · · ·	e links provided to obtain the c	urrent versions	of each form.		Helpful Links	Submitted		
	Outdated versions of for 1. Coversheet for Fax/Em					Coversheet for			
						<u>Fax/Email</u>			
	2. Group Application Che	ecklist							
	3. List of Service Locations (Required if you answered Yes to question 1 above)								
	4. <u>W-9 (10-2018)</u>	Printed Name of Signing Managin	g Employee:			<u>W-9 (10-2018)</u>			
(0						What is the			
ents	5. CP 575/147C (Not requ	uired if submitting a FEDERAL ta	x exempt lette	r issued by the IRS)		<u>CP575/147C?</u>			
3: mě	6. IRS Tax Exempt Letter	(Required if you answered Yes t	-	-		IRS Tax Exempt Letter for Government			
		If Exempt from FEDERAL Taxes, submi cannot be substituted. The letter mus			ate issued letter	Agencies			
ਰ ਹੋ	7. License. License must l below, and must not be	be from one of your rendering p	practitioners, m	ust cover the effec	tive date				
di ,	License #	• •		Expires:					
Req	8. NPI prinout from the N	IPPES Website				NPPES Website			
			_						
	9. <u>SFN 661 (12-2022)</u> 9a. Bank Letter/Vo	Printed Name of Signing Managin		provided on the SEN f	561	<u>SFN 661 (12-2022)</u>			
	9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661								
	10. Claim (Required if yo								
	11. <u>SFN 1168 (8-2020)</u>					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 M	embers attached to Section III (Pag	ge 2) with dates o	of birth and SSNs.					
	12. <u>SFN 615 (6-2023)</u>	Printed Name of Signing Managing	• • •	1 I	1 <b>.</b>	<u>SFN 615 (6-2023)</u>			
		equired for any application. If proof ensure that the necessary insuran							
	PROVIDER TYPE	026- Ambulatory I	Health Care Fac	ilities					
G	SPECIALTY/Taxonomy (Please Choose One)	503-Single Specialty 193400000X		lti-Specialty 200000X					
Date									
Ne		th your billing department date. <b>The Department v</b>							
Effective		roved and any claims sub my. A retroactive enrollme							
	days** prior to the o	date a <b>complete</b> applicati	ion packet is	received by the	e Departmen	t. If the date			
4: ent		the 90 day timeframe, th mplete application packet			assigned will	be 90 days			
ection 4: rollment									
	ys prior to the date a ation documents.								
В П С П									
<u> </u>			ייייייי ר	<u>.</u>					
0	Requested Enrollment Ef Printed Name of		I				1		
2									
ахо	Person Requesting the Effective Date			Date					

### Group Application Checklist Methadone/Suboxone (026 - 509)

**<u>Click Here</u>** for the Medication Assisted Treatment (MAT) Policy

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #							
		Provider Name							
	u O I	Organizational NPI #							
-	Jati								
÷:	un de la contra de	Service Address							
uo .	Identitying Intormation	Billing Address							
Section		Mailing Address							
S.		Facility Phone							
	leni	Contact Person							
	<u> </u>	Phone							
		Email							
		I							
		1. Are you Enrolled in Me			VES				
		Is your Medicare Red	our Medicare ID:		□ <b>NO</b>	□ YES			
	:		-	State)					
		2. Are you Enrolled in Me State Abbv:	alcald in another	State?	Please Prov	ID NO ide your Other Sta	TES YES		
2:		3. Are you enrolling any a				-		□ YES	
	suc		Provider Type, NP Please note: Service a	PI, EIN, and billin ddresses located w out of state service	ng address). vithin North Dake e locations. Out e	of all service locati ota and bordering citie of state service location	rs (within 50 miles of	the ND border) canno	ot be enrolled
Section	lestio	4. Are you exempt from F	EDERAL taxes?	□ YES		f Exempt from FEDER/	<mark>AL</mark> Taxes, submit you	ur I <mark>RS</mark> issued Tax Exen	npt Letter.
Se	Du	5. Do you have any Indivio (Interest may be direct or		es which have 5	% or more int	erest in the enrolli	ing group?	□ YES	□ NO
		6. How many Managing E If more than 3 Managing Empl List must contain First Names,	oyees, attach a list as	part of Section III			nave?		
		7. Are you organized as a corporation?	corporation, a no	n-profit corpora	ation, or a gov	vernment agency o	organized as a	□ YES	
			<b>7a. If Yes, how m</b> If more than 3 Board 1168 (page 2).	-	-				
		8. Have you had full and cor (If yes, submit a copy of you						☐ YES	
		9. Please select the Medi				-			
			Methadone	[	Suboxone				
	1								
		I have read and acknowle enrollments) are required etc.) and the individual re must be linked ("affiliated are not actively enrolled application is approved.	d. In order to bill o endering provider d") to the billing p	n a professiona /s must be enro rovider record	al claim form, olled. Also, th in the system	the billing group ( e rendering provid . For all rendering	clinic, practice, ler's record providers who	Enter Initia (required for o	

		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								
		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. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>									
	nued	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	What is the CP575/147C?									
	tin		<u>CF3/3/14/C:</u>									
	LOU	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	IRS Tax Exempt Letter for Government									
.: .:	ts (	cannot be substituted. The letter must be issued by the IRS.	Agencies									
_	Jen	7. SAMHSA - Required if you are providing Methadone (It is the responsibility of the provider to keep										
Section	un	updated certification information on file with the state by submitting a copy of the updated certificate to provider enrollment each time it is renewed)										
Se	000	Effective: Expires:										
	ed	8. Y DEA of a practitionar. Paguirad if you are providing Subayana (It is the remancibility of the provider to										
	uire	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										
	led	practitioner by submitting a copy of the X DEAs to provider enrollment each time they are renewed)										
	2	X DEA Number: Effective: Expires:										
		9. NPI prinout from the <u>NPPES Website</u>	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. <u>SFN 1168 (8-2020)</u>	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:	<u>SFN 615 (6-2023)</u>									
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be d										
	0)	provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be	e submitted for any ap	plication.								
	)ate	PROVIDER TYPE026- Ambulatory Health Care FacilitiesSPECIALTY509-Methadone (this specialty/taxonomy combination is for Methadone and/or Suboxone)										
	/e D	TAXONOMY261QM2800X										
4:	ctiv											
Section	Effective	Please coordinate with your billing department and any other applicable area to determ enrollment effective date. The Department will not make changes to that date or										
ect	entE	application is approved and any claims submitted with a date of service prior to the	enrollment									
S	me	effective date will deny. A retroactive enrollment effective date is limited to no more th days* prior to the date a <b>complete</b> application packet is received by the Department.										
		requested is outside the 90 day timeframe, the enrollment effective date assigned will										
	from the date the complete application packet was received.											

n 4: fective Date iued		•	•	•	•	more than 90 days prior to the date a with your application documents.		
	This application is	associated with an o	emergency servi	ce. We are requ	uesting the date of _	Refer to the * above.		
Sectio ent Eff Contin	Requested Enrollment Ef	fective Date						
Se Enrollmen Co	Printed Name of Person Requesting the Effective Date				Date			
ш	Click Here to find more information on Effective Dates and Retro Effective Date Policies							
	Revision	8/22/2023						

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

Are you a Mental Health "Rehab" group?

<u>Click Here</u> for the ND Medicaid State Plan for Rehabilitative Services.

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #							
		Provider Name							
	Information	Organizational NPI #							
	nat								
1:	or	Service Address							
		Billing Address							
Section	ing	Mailing Address							
S	tify	Facility Phone							
	dentifying	Contact Person							
	_	Phone							
		Email							
		1. Are you Enrolled in Me	dicare?						
		Please Provide your M				_			
			ecord up to date?			☐ YES			
		2. Are you Enrolled in Mo		State?			U YES		
		State Abby			Please Pr	ovide your Other S	tate Medicald ID:		
Section 2:	uestions		Provider Type, NP Please note: Service of	PI, EIN, and addresses loca record as out a	billing address). Ited within North E of state service loca	s of all service loca akota and bordering c tions. Out of state serv	ities (within 50 miles	s of the ND border) c	annot be
Š	Ø	4. Are you an Out of State	Provider (Service	location m	ore than 50 mile	es from the North L	Dakota	□ YES	
						o an eligible ND Mo			
		your enrollmer	t documents. The		vice on the clain	n must support you	r requested effec	tive date for enro	ollment.
		5. Are you exempt from	EDERAL taxes?	☐ YES		If Exempt from FEDER	RAL Taxes, submit you	ur IRS issued Tax Exe	mpt Letter.
		6. Do you have any Indivi (Interest may be direct o		es which ha	ve 5% or more i	nterest in the enrol	lling group?	□ YES	
		7. How many Managing I	Employees (author	rized to sign	on behalf of th	e business) do you	have?		
		If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section	on III of the SFN 116				
		8. Are you organized as a corporation?	corporation, a noi	n-profit cor	poration, or a g	overnment agency	organized as a	☐ YES	□ NO
			8a. If Yes, how ma If more than 3 Board the SFN 1168 (page 2	Members, at	-				
	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.								

Mental dise with the ex	enrolling facility provide residential or inpatient services to individuals with mental diseases? ases are diseases listed as mental disorders in the International Classification of Diseases (ICD), ception of intellectual disability, senility and organic brain syndrome. Substance use disorders red a mental disease. If Yes, answer questions 9a-9c below.
nued	9a. Does your organization or governing body have any other facilities that          Yes          provide residential or inpatient services to individuals with mental         diseases?         If yes, provide a list with the addresses of each location.
Section 2: ( Contir	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

		The documents requested below must be returned to the Department in order to process	your enrollmen	t	
		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. <u>Coversheet for Fax/Email</u>		<u>Coversheet for</u> <u>Fax/Email</u>	
		2. Group Application Checklist			
		3. List of Service Locations (Required if you answered Yes to question 3 above)			
		4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:		<u>W-9 (10-2018)</u>	
3: cuments		5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>	
		6. IRS Tax Exempt Letter (Required if you answered Yes to question 5 above)		IRS Tax Exempt Letter	
	ts	If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A St	for Government		
	.ue	cannot be substituted. The letter must be issued by the IRS.	<u>Agencies</u>		
	<u>E</u>	7. License. License must be from one of your rendering practitioners, must cover the effect below, and must not be expired.			
Section	Doc	License # Issued: Expires:			
ect.		8. NPI prinout from the <u>NPPES Website</u>		NDDES Wohsite	
Š	lire I	8. NPI prinout from the <u>NPPES Website</u>	<u>NPPES Website</u>		
	edr	9. <u>SFN 661 (12-2022)</u> Printed Name of Signing Managing Employee:		<u>SFN 661 (12-2022)</u>	
	å	9a. Bank Letter/Voided Check Must match the Information provided on the SFN 66	51		
		10. Rehab Questionnaire		Rehab Questionnaire	
				Renab Questionnaire	
		11. <u>SFN 9 (5-2021)</u>		<u>SFN 9 (5-2021)</u>	
	1	12. Claim (Required if you answered Yes to question 4 above) Claims submitted are for Enrollment	at Dumpered Only		
		12. Claim (Required if you answered res to question 4 above) claims submitted are for Enrollmen	it Purposes Only		
		13. <u>SFN 1168 (8-2020)</u>		Simplified Instructions based on FAQs	
		13a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs	<b>.</b>	<u>raus</u>	
		13b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.			
	1				
		14. SFN 615 (6-2023)       Printed Name of Signing Managing Employee:		<u>SFN 615 (6-2023)</u>	
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an appli- provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is			

	_	PROVIDER TYPE	26- Ambulatory Health Care Facilities								
		SPECIALTY	50-Mental Health (Incl. Comm Mntl Hlth)								
	-	TAXONOMY	51QM0801X								
		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									
Section 4:	Enrollment Effective	enrollment effective <b>application is app</b> effective date will de days* prior to the d requested is outside from the date the co *If this application is assoc complete application pack This application is Requested Enrollment E Printed Name of Person Requesting the Effective Date	A your billing department and any other applicable area to determine the correct ate. The Department will not make changes to that date once the yed and any claims submitted with a date of service prior to the enrollment y. A retroactive enrollment effective date is limited to no more than ninety (90 e a complete application packet is received by the Department. If the date the 90 day timeframe, the enrollment effective date assigned will be 90 days applete application packet was received. ed with an emergency service, the Department may consider a date more than 90 days prior to the date is received. You must include a copy of the claim and medical records with your application documents. sociated with an emergency service. We are requesting the date of Refer to the * abov ctive Date	)) 9 a							
		CIICK	are 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?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #										
	Provider Name										
ion	Organizational NPI #										
nat											
1: orn	Service Address										
ion Infe	Billing Address										
Section ying Inf	Mailing Address										
Section 1: Identifying Information	Facility Phone										
ent	-										
Id	Contact Person										
	Phone										
	Email										
							L				
	1. Are you Enrolled in Me			VES							
	Is your Medicare Re	your Medicare ID:		□ <b>NO</b>		s					
	2. Are you Enrolled in Me		State?				☐ YES				
	State Abbv:			Please Prov	ide your C	Other Sta	te Medicaid ID:				
Section 2: Questions	3. Are you enrolling any a	If yes, please inclu Provider Type, NP Please note: Service a in the same record as services have been pr	ude a list with t PI, EIN, and billi addresses located v s out of state servio	he addresses ng address). vithin North Dak ce locations. Out	of all servi	ice locati dering citie	es (within 50 miles o	f the ND	border) can	not be enr	
0, 0	4. Are you an Out of Stat	e Provider (Service	location more	than 50 miles	from the	North D	akota		YES		NO
	border?) If yes, a copy o	f the claim for the	service that wa	s provided to	an eligibl	e ND Me	dicaid Recipient	: must b		L ted with	
		nt documents. The		•	•		•				
	5. Are you exempt from	FEDERAL taxes?	□ YES		lf Exempt fro	om FEDER	AL Taxes, submit yo	ur <mark>IRS</mark> iss	ued Tax Exe	empt Lette	r.
	· · · · ·										
	6. Do you have any Indivi (Interest may be direct o		es which have 5	% or more int	erest in tr	ne enroll	ing group?		YES		NO
	7					d a a la					
	7. How many Managing E If more than 3 Managing Emp		-		-	ao you n	ave?				
	List must contain First Names	, Last Names, Dates of	Birth, and SSNs								
	8. Are you organized as a	corporation, a nor	n-profit corpora	ation, or a gov	ernment	agency o	organized as a		YES		NO
	corporation?	8a. If Yes, how ma If more than 3 Board SFN 1168 (page 2).	-	-		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.										

		The documents requeste	d below must be r	eturned to the	e Department	in order to process	your enrollmen	t	
		Please ensure you use th			urrent version	s of each form.		Helpful Links	Submitted
		Outdated versions of for		epted.				Coversheet for	
		1. <u>Coversheet for Fax/Em</u>	ail					Fax/Email	
		2. Group Application Che	ecklist						
				_					
		3. List of Service Location	is (Required if you	answered Yes	s to question 3	above)			
		4. <u>W-9 (10-2018)</u>	Printed Name of Si	gning Managing	g Employee:			<u>W-9 (10-2018)</u>	
	nts	5. CP 575/147C (Not requ	ired if submitting	a FEDERAL tax	x exempt lette	r issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>	
	ω.	6. IRS Tax Exempt Letter	Required if you a	nswered Ves to	o question 5 al	nove)		IRS Tax Exempt Letter	
n 3:	ocum	o. no fax Exempt Letter		RAL Taxes, submit	t your I <mark>RS</mark> issued	Tax Exempt Letter. A Sta	ate issued letter	for Government Agencies	
Section		7. License. License must k	pe from one of you	ır rendering Pl	hysical Therap	ists. must cover the	effective		
	red	date below, and must no				- 			
	qui	License #		Issued:		Expires:			
	Re	8. NPI prinout from the N	IPPES Website					NPPES Website	
		9. SFN 661 (12-2022)	Printed Name of Si	gning Managing	g Employee:			SFN 661 (12-2022)	
		9a. Bank Letter/Vo	ded Check	Must match th	ne Information p	provided on the SFN 6	61		
		10. Claim (Required if yo	u answered Yes to	question 4 ab	OVe) Claims subi	nitted are for Enrollme	nt Purposes Only		
		11. <u>SFN 1168 (8-2020)</u>						Simplified Instructions based on FAQs	
		11a. List of Managin	g Employees attach	ed to Section III	(Page 2) with d	ates of birth and SSN	S		
		11b. List of Board M	embers attached to	Section III (Page	e 2) with dates o	of birth and SSNs.			
		12. SFN 615 (6-2023)	Printed Name of Si	ning Managing	Fmplovee:			SFN 615 (6-2023)	
		Proof of Insurance is not rec	uired for any applic	ation. If proof of	f insurance is su			leleted from the file. It	
		provider's responsibility to			•	proof of insurance is	not required to b	be submitted for any ap	plication.
		PROVIDER TYPE SPECIALTY	026- Ambulatory He 110-Physical Therap		ties				
		TAXONOMY	261QP2000X	, y					
	e	Please coordinate wi							
	Date	enrollment effective application is appr							
		effective date will de days* prior to the da							
n 4:	fective	requested is outside from the date the co	the 90 day tim	neframe, the	e enrollmen	t effective date			
ection	t Effe								
Sec	men	*If this application is associ complete application packe		•	•	-	•	-	
	Enroll	This application is	associated with an o	emergency serv	vice. We are req	uesting the date of	1	Refer to the * above.	
	ш	Requested Enrollment Ef	fective Date						
		Printed Name of Person			1				
		Requesting the Effective Date				Date			
		Click H	lere to find more i	information o	n Effective Dat	es and Retro Effect	ive Date Policies	2	

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

**<u>Click Here</u>** for more information about Coverage of Medicaid Addiction Treatment Services

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #									
	_	Provider Name									
	Identifying Information	Organizational NPI #									
	L	Service Address									
UO	Info	Billing Address									
Section	n B C	Mailing Address									
Š	tifyi	Facility Phone									
	lden	Contact Person									
	_	Phone									
		Email									
		Is your Medicare Re	your Medicare ID: cord up to date?	□ NO	YES NO	□ YES					
		2. Are you Enrolled in Me		State?							
		State Abbv:			Please Prov	ide your Other Sta	te Medicald ID:				
n 2:	ons		If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been pr	ude a list with t PI, EIN, and billi ddresses located w out of state servic	the addresses ing address). vithin North Dako se locations. Out c	of all service locati	; (within 50 miles of	f the ND bo	order) cann	he same	NO led
Section	uestio	4. Are you an Out of State	e Provider (Service	location more	than 50 miles	from the North Da	ikota		YES		NO
Se	Qu		f the claim for the t documents. The								
		5. Are you exempt from I	FEDERAL taxes?	☐ YES		Exempt from FEDERA	L Taxes, submit you	ur <mark>IRS</mark> issue	ed Tax Exe <sup>,</sup>	mpt Letter.	
		6. Do you have any Indivi (Interest may be direct o		es which have 5	5% or more int	erest in the enrolli	ng group?		YES		NO
		7. How many Managing E If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section III		• •	ave?				
		8. Are you organized as a corporation?					rganized as a		YES		NO
			8a. If Yes, how ma If more than 3 Board 1168 (page 2).	-							
		9. Please indicate which A ASAM levels, you must in found in the list below a	nform the Departm	nent in advance	e and submit t		-	-	-		
		ASAM Levels:	□ 1	2.1	2.5	3.1	3.2		3.5	3.7	

enrollments) are etc.) and the inc must be linked ( are not actively	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.							
10. Do you have	Accreditation? (If yes, please submit copy) 🗌 YES 🗌 NO							
Mental diseases with the except	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.							
	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					
5	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							

		The documents requested below must be returned to the Department in order to process your enrollment											
		Please ensure you use the links provided to ol Outdated versions of forms will not be accep		rrent versions	of each form.		Helpful Links	Submitted					
		1. <u>Coversheet for Fax/Email</u>					<u>Coversheet for</u> Fax/Email						
		2. Group Application Checklist											
		3. List of Service Locations (Required if you answered Yes to question 3 above)											
		4. <u>W-9 (10-2018)</u> Printed Name of Signi	ing Managing	g Employee:			<u>W-9 (10-2018)</u>						
tion 3: Documents	lents	5. CP 575/147C (Not required if submitting a	)	<u>What is the</u> <u>CP575/147C?</u>									
	Docum	6. IRS Tax Exempt Letter (Required if you answ If Exempt from FEDERAL cannot be substituted.	IRS Tax Exempt Letter for Government Agencies										
Section	equired	7. Program License (ASAM License) (It is the resp with the state by submitting a copy of the license to pro											
	edr	License # Iss	sued:		Expires:								
	۳	8. Accreditation (Required if you answered Ye	es to questic	on 10 above)									
		9. NPI prinout from the <u>NPPES Website</u>					NPPES Website						
		10. <u>SFN 661 (12-2022)</u> Printed Name of Sign	ing Managin	g Employee:			<u>SFN 661 (12-2022)</u>						
		10a. Bank Letter/Voided Check M	lust match th	e Information p	provided on the SFN (	661							
		11. <u>SFN 9 (5-2021)</u>					<u>SFN 9 (5-2021)</u>						
		12. Claim (Required if you answered Yes to qu	uestion 4 ab	ove) <mark>Claims sub</mark>	mitted are for Enrollmo	ent Purposes Only							

Section 3: Required Documents Continued	12. <u>SFN 1168 (8-2020)</u>						Simplified Instructions based on <u>FAQs</u>			
Section 3: red Docum Continued	12a. List of Managin	g Employees attach	ed to Section III	(Page 2) with d	ates of birth and SSN	S				
Sect ired I Cont	12b. List of Board M	embers attached to	Section III (Page	e 2) with dates	of birth and SSNs.					
sedu										
Ľ	13. <u>SFN 615 (6-2023)</u>	Printed Name of Sig	ning Managing	Employee:			<u>SFN 615 (6-2023)</u>			
	Proof of Insurance is not rec provider's responsibility to									
	PROVIDER TYPE	026- Ambulatory He	ealth Care Facilit	ies						
ate	SPECIALTY	364-Rehabilitation,								
Da:	TAXONOMY 261QR0405X									
	·									
ion 4: Effective	Already Know your Taxonomy? Click here to find out which Provider Type & Specialty is assigned to your Taxonomy									
n 4 fec	http://www.nd.gov/dhs/info/mmis/docs/mmis-group-provider-code-taxonomy.pdf									
Section Enrollment Effe	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									
	s prior to the date a ation documents. Refer to the * above.									
	Requested Enrollment E									
	Printed Name of Person Requesting the Effective Date				Date					
		Here to find more	information o	n Effective Da	tes and Retro Effec	tive Date Policie	<u>s</u>			
	Revision	8/22/2023								

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 <u>Hospital Professional Billing</u> <u>Group</u>.

Have Questions?	
Click Here for FAQs and More Resources	
All 4 Sections and Fields are Required unless specifically marked as not required	

Application Tracking # \_\_\_\_\_\_ Provider Name \_\_\_\_\_\_ Organizational NP1 # \_\_\_\_\_ Service Address \_\_\_\_\_\_ Only 1 service location may be enrolled per Medicaid ID. Billing Address \_\_\_\_\_\_ Facility Phone \_\_\_\_\_\_ Contact Person \_\_\_\_\_\_ Phone \_\_\_\_\_\_ Email \_\_\_\_\_\_

	1. Are you Enrolled in Medicare?		☐ YES	Medicare Enrollme	nt is required		
	Please Provide your Medicare ID:						
	Is your Medicare Record up to date?		<mark>∏ NO</mark>	U YES			
2: ns	2. Are you exempt from FEDERAL taxes?	□ YES		If Exempt from FEDERA	<mark>L</mark> Taxes, submit you	ır I <mark>RS</mark> issued Tax Exe	empt Letter.
	3. Do you have any Individuals or Business (Interest may be direct or indirect)	es which hav	ve 5% or more	interest in the enrolli	ng group?	□ YES	□ NO
Section Questio	<b>4. How many Managing Employees (autho</b> If more than 3 Managing Employees, attach a list a List must contain First Names, Last Names, Dates o	s part of Section	n III of the SFN 11	• •	ive?		
	5. Are you organized as a corporation, a no corporation?	on-profit corp	poration, or a g	overnment agency o	ganized as a	□ YES	□ NO
	5a. If Yes, how m If more than 3 Board SEN 1168 (page 2).	•	•				

	The documents requested below must be returned to the Department in order to process your enrollmen	t	
	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
nts	1. <u>Coversheet for Fax/Email</u>	Coversheet for Fax/Email	
ne			
	2. Group Application Checklist		
		-	
°⊇ŏ	3. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>	
ס ט			
Section Jired Do	4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>	
ō		-	
Be	5. IRS Tax Exempt Letter (Required if you answered Yes to question 2 above)	IRS Tax Exempt Letter	
	If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter	for Government	
	cannot be substituted. The letter must be issued by the IRS.	<u>Agencies</u>	

	6. License. License must be from one of your MD practitioners, must cover the effective date below, must not be expired.	and
ed	License # Issued: Expires:	
ntinu	7. CMS RHC Certification Letter	
S	8. NPI printout from the <u>NPPES Website</u>	NPPES Website
on 3: ents	9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>
ectic	9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661	
	10. <u>SFN 1168 (8-2020)</u>	Simplified Instructions based on FAQs
uired	10a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs	
Requ	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 w provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not require	
	<b>PROVIDER TYPE</b> 026- Ambulatory Health Care Facilities	
	SPECIALTY   268-Rural Health Clinic	
	TAXONOMY261QR1300X	
tion 4: Effective Date	Please coordinate with your billing department and any other applicable area to de enrollment effective date. <b>The Department will not make changes to that dat</b> <b>application is approved</b> and any claims submitted with a date of service prior to effective date will deny. A retroactive enrollment effective date is limited to no mod days** prior to the date a <b>complete</b> application packet is received by the Depart requested is outside the 90 day timeframe, the enrollment effective date assigned from the date the complete application packet was received.	te once the the enrollment re than ninety (90) ment. If the date
Section 4: Enrollment Effect	**If this application is associated with an emergency service, the Department may consider a date more than complete application packet is received. You must include a copy of the claim and medical records with your This application is associated with an emergency service. We are requesting the date of	
Enrc	Requested Enrollment Effective Date	
	Printed Name of Person     Date       Requesting the     Date       Effective Date     Date	
	Click Here to find more information on Effective Dates and Retro Effective Date Pe	blicies
	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

		Application Tracking #								
		Provider Name								
	<u>io</u>	Organizational NPI #								
	nat									
÷:	orn	Service Address								
ion	Inf	Billing Address								
Section	ы С	Mailing Address								
Se	Identifying Information	Facility Phone								
	int									
	lde	Contact Person								
		Phone								
		Email								
		-								
		1. Are you Enrolled in Me Please Provide	edicare? your Medicare ID:		□ YES	Medicare Enrollm	ent is required			
		Is your Medicare Re	-			YES				
					Para da ba				VEC	
		2. Are you enrolling any a				e at this time? ses of all service loca	tions being enrol	 led (mu	YES Ist have t	NO ne same
			Provider Type, NF							
2:	JS					Dakota and bordering citi Out of state service locat				
u c	ioi		services have been pi			Out of state service local	ions will only be en	uncu m u	n out of stu	ie record ij
Section	S				location.					
Se	e	3. Are you an Out of State				iles from the North D	Jakota			
	Questio	3. Are you an Out of State border?)	e Provider (Service	location mo	re than 50 m				YES	□ NO
	Que	border?) If yes, a copy of	e Provider (Service f the claim for the	e location mo	re than 50 m was provideo	iles from the North D I to an eligible ND Me im must support you	edicaid Recipient		e submitt	ed with
• • •	Que	border?) If yes, a copy of your enrollmer	e Provider (Service f the claim for the nt documents. The	e location mo service that v date of servio	re than 50 m was provideo ce on the cla	l to an eligible ND Me im must support you	edicaid Recipient r requested effec	tive dat	e submitt e for enro	ed with Illment.
•,	Que	border?) If yes, a copy of	e Provider (Service f the claim for the nt documents. The	e location mo	re than 50 m was provideo	l to an eligible ND Me	edicaid Recipient r requested effec	tive dat	e submitt e for enro	ed with Illment.
	Que	border?) If yes, a copy of your enrollmer 4. Are you exempt from I 5. Do you have any Indiv	e Provider (Service f the claim for the nt documents. The FEDERAL taxes? iduals or Business	e location mo service that v date of servio	re than 50 m was provided ce on the cla	l to an eligible ND Me im must support you If Exempt from FEDER	edicaid Recipient r requested effec AL Taxes, submit you	tive dat	e submitt e for enro	ed with Illment.
	Que	border?) If yes, a copy of your enrollmer 4. Are you exempt from I	e Provider (Service f the claim for the nt documents. The FEDERAL taxes? iduals or Business	e location mo service that v date of servio	re than 50 m was provided ce on the cla	l to an eligible ND Me im must support you If Exempt from FEDER	edicaid Recipient r requested effec AL Taxes, submit you	tive dat	e submitt e for enro led Tax Exe	ed with ollment. mpt Letter.
	Que	border?) If yes, a copy of your enrollmer 4. Are you exempt from I 5. Do you have any Indiv (Interest may be direct o 6. How many Managing I	e Provider (Service f the claim for the it documents. The FEDERAL taxes? iduals or Businesse r indirect) Employees (author	e location mo service that w date of servic YES es which have rized to sign c	re than 50 m was provided ce on the cla NO e 5% or more on behalf of t	I to an eligible ND Me im must support you If Exempt from FEDER interest in the enrol	edicaid Recipient r requested effec AL Taxes, submit you ling group?	tive dat	e submitt e for enro led Tax Exe	ed with ollment. mpt Letter.
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Mental dis with the ex	e enrolling facility provide residential or inpatient services to individuals with mental diseases? seases are diseases listed as mental disorders in the International Classification of Diseases (ICD), xception of intellectual disability, senility and organic brain syndrome. Substance use disorders I Yes I No ered a mental disease. If Yes, answer questions 8a-8e below.
5	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.)
3	8b. Does your facility have specific beds or units that are allocated for services Yes No for individuals with mental diseases?
	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 Yes No services for individuals with mental diseases?
	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.

		The documents requested below must b	e returned to the Departmen	t in order to process	your enrollmen	t	
		Please ensure you use the links provided Outdated versions of forms will not be a		ns of each form.		Helpful Links	Submitted
		1. <u>Coversheet for Fax/Email</u>				<u>Coversheet for</u> Fax/Email	
		2. Group Application Checklist					
		3. List of Service Locations (Required if y	ou answered Yes to question	2 above)			
	nts	4. <u>W-9 (10-2018)</u> Printed Name of	Signing Managing Employee:			<u>W-9 (10-2018)</u>	
.: .:	cume	5. CP 575/147C (Not required if submitting	ng a FEDERAL tax exempt let	ter issued by the IRS	)	<u>What is the</u> <u>CP575/147C?</u>	
Section	red Doo	-	I answered Yes to question 4 DERAL Taxes, submit your I <mark>RS</mark> issue uted. The letter must be issued by	d Tax Exempt Letter. A S	tate issued letter	IRS Tax Exempt Letter for Government Agencies	
-	equi	<b>7. Hospital License</b> (It is the responsibility of the submitting a copy of the license to provider enrolling the license to provider enrolling the license to provide the license to p	ne provider to keep updated licensu ment each time it is renewed)	re information on file wit	h the state by		
	Ř	License #	Issued:	Expires:			
		<b>8. Unit License</b> (It is the responsibility of the prosubmitting a copy of the license to provider enroll		formation on file with the	e state by		
		License #	Issued:	Expires:			
		9. NPI prinout from the <u>NPPES Website</u>				NPPES Website	
		10. SFN 661 (12-2022) Printed Name of	f Signing Managing Employee:			<u>SFN 661 (12-2022)</u>	
		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 su	Ibmitted are for Enrollm	ent Purposes Only		

							Simplified	
nts	12. <u>SFN 1168 (8-2020)</u>						Instructions based on	
mer t		<u>FAQs</u>						
Section 3: red Docum Continued	11a. List of Managir	ng Employees attach	ed to Section III	(Page 2) with d	ates of birth and SSNs			
Section 3: Required Documents Continued	11b. List of Board N	Aembers attached to	Section III (Pag	e 2) with dates	of birth and SSNs.			
ledi								
Ч	13. <u>SFN 615 (6-2023)</u>	Printed Name of Sig	ning Managing	Employee:			<u>SFN 615 (6-2023)</u>	
	Proof of Insurance is not re- provider's responsibility to							
	provider s responsibility to			is in place, but		or required to be	e submitted for any appr	
	PROVIDER TYPE	027- Hospital Units						
	SPECIALTY	364-Rehabilitation,	Substance Use [	Disorder Unit				
	TAXONOMY	276400000X						
Section 4: Enrollment Effective Date	Requested Enrollment E Printed Name of Person Requesting the Effective Date <u>Click</u>	e date. The Dep roved and any eny. A retroacti- late a complete the 90 day tin omplete applica ciated with an emerg set is received. You m s associated with an ffective Date	claims subr ve enrollmer e application neframe, the tion packet gency service, the nust include a co emergency serv	vill not main nitted with nt effective packet is ne e enrollmen was receive e Department r opy of the claim ice. We are req	ke changes to t a date of service date is limited to received by the D t effective date a ed.	hat date o prior to the promore th Department. essigned will ore than 90 days vith your applica	<b>nce the</b> e enrollment han ninety (90) If the date be 90 days s prior to the date a ation documents. Refer to the * above.	
	Revision	8/22/2023						L

Page 3 of 3

Swingbed (027 - 196)

Have Questions? Click Here for FAQs and More Resources

Provider Name   Organizational NPI #   Service Address   Billing Address   Mailing Address   Mailing Address   Foodder Name   Contact Person   Phone   Email   I Are you Enrolled in Medicare?   NO   YES   Medicare Enrollment is required   Ploase Provide your Medicare ID:   Is your Medicare Record up to date?   NO   YES   NO   YES   NO   YES   NO   YES   NO   YES    No   YES   No   YES   No   YES    No   YES    No   YES    No   YES    No    YES    No   YES    No   YES    No   YES    No   YES    No   YES    No   YES    No   YES    No    YES    No   YES    No   YES    No   YES    No   YES    No    YES    No   YES    No   State Provider (Service location more than 50 miles of the ND border) cam			Application Tracking #									
Organizational NPI #         Service Address         Billing Address         Billing Address         Contact Person         Phone         Email         Interview of the service of the												
Phone       Email         Image: Second s	n 1:	C										
Phone       Email         Image: Second s		atio	Organizational NPI #									
Phone       Email         Image: Second s		E E	Service Address									
Phone       Email         Image: Second s		for										
Phone       Email         Image: Second s	tio											
Phone       Email         Email <ul> <li>Are you Enrolled in Medicare?</li> <li>NO</li> <li>YES</li> <li>YES</li> <li>NO</li> <li>If yes, please note: Service locations not listed above at this time?</li> <li>YES</li> <li>NO</li> <li>If yes, a copy of the claim for the service location.</li> </ul> <li>Are you an Out of State Provider (Service location more than 50 miles from the North Dakota</li> <li>YES</li> <li>NO</li> <li>If yes, a copy of the claim for the service on the claim must support your requested effective date for enrollment.</li> <li>Are you exempt from FEDERAL taxes?</li> <li>YES</li> <li>NO</li> <li>If exempt from FEDERAL taxes?</li> <li>YES</li> <li>NO<td>O O</td><td>ing</td><td>Mailing Address</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></li>	O O	ing	Mailing Address									
Phone       Email         Image: Second s	S	tif	Facility Phone									
Phone       Email         Image: Second s		ent										
Email         1. Are you Enrolled in Medicare?       N0       YES       Medicare Enrollment is required Please Provide your Medicare ID: Is your Medicare Record up to date?       N0       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).       YES       NO         Searce and: Service addresses located within North Oktoba and bordering cites (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 bave been provided at each location.       NO         3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         broder?)       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         5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES       NO         6. How many Managing Employees (authorized to sign on behalf of the business) do you have?       Iffrome than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2). List must contain Fi		σ										
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         Please Provide Type, NPI, EIN, and billing address).       Please once: Service address located within North Dokota and bordering atties (within 50 miles of the ND border) cannot be enrolled line the same provided travers have been provide to service locations. Out of state service locations will only be enrolled in an out of state record if services have been provided to each location.         3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         border?)       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         5. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES       NO         6. How many Managing Employees (authorized to sign on behalf of the business) do you have?       If more than 3 Managing Employees (authorized to sign on behalf of the business) do you have?       NO         7a. If Yes, how many Board Members do you have?       If more than 3 Board Members do you have?       NO<												
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).       YES       NO         Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in stame 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?) 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?       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         7. Are you organized as a corporation, a non-profit corporation, or a governme			Email									
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).       YES       NO         Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of the ND border) cannot be enrolled in stame 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?) 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?       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         7. Are you organized as a corporation, a non-profit corporation, or a governme												
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, NP), EN, and billing address).       NP desente: 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 to each location.         3. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       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 therest may be direct or indirect)       If senses which have 5% or more interest in the enrolling group?       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 lis6 (page 2).       NO         7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a       YES       NO         7. Are you organized as a coropration, a non-profit corporation,			-				Medicare Enrollmo	ent is required				
Are you enrolling any additional service locations not listed above at this time?     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 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.     Are you an Out of State Provider (Service location more than 50 miles from the North Dakota     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.     Are you exempt from FEDERAL taxes? YES NO     If exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.     S. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? YES NO     If more than 3 Manging Employees (authorized to sign on behalf of the business) do you have?     If more than 3 Manging Employees, attach a list as part of Section III of the SFN 1168 (page 2).     Its must contain First Names, Last Names, Dates of Birth, and SSNs     T. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a Corporation?     Ta. If Yes, how many Board Members, attach a list as part of Section III of the SFN 1168 (page 2).     Itage as a difference of the section III of the SFN 1168 (page 2).			-				□ YES					
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) 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?       YES       NO         6. How many Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       NO         7. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation, a non-profit corporation, or a government agency organized as a corporation, a non-profit corporation, or a government agency organized as a		i	-	•								
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         a. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         border?)       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?       YES       NO         If Exempt from FEDERAL taxes?       YES       NO         If Are you exempt from FEDERAL taxes?       YES       NO         If Are you exempt from FEDERAL taxes?       YES       NO         If Exempt from FEDERAL taxes?       YES       NO         If more than 3 Managing Employees (authorized to sign on behalf of the business) do you have?       YES       NO         If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       Ist must contain First Names, Last N								iono hoing onvol				NO
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								lions being enro	ied (must	nave the s	ame	
services have been provided at each location.         3. Are you an Out of State Provider (Service location more than 50 miles from the North DakotaYESNo         border?)         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							-			•		
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1168 (page 2).												P
8 What is the name and Medicaid ID. Application Tracking Number, or NDI of the Attending physician which will be an usur elemed					Members, attach a	a list as part o	f Section III of the SFN					
			0 M/h = + := + h = m = m = = = =		· Tue elsis	- Nik						
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:			-			Madica						
Name: Medicaid ID/ATN/NPI:			ivaille:			IVICUILA						

Page	2	of	3
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	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
Section 2: Questions Continued	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.)				
ction 2: Cont	9b. Does your facility have specific beds or units that are allocated for services for individuals with mental diseases?		Yes		No
Sec	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
	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.	Hel	pful Links	Sul	omitted
	1. <u>Coversheet for Fax/Email</u>		ersheet for ax/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)		

	nts	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>	
	le			
$\ddot{\sim}$	Ę	6. IRS Tax Exempt Letter (Required if you answered Yes to question 4 above)	IRS Tax Exempt Letter	
Ċ	บ	If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter. A State issued letter	for Government	
ō	0	cannot be substituted. The letter must be issued by the IRS.	<u>Agencies</u>	
H				
a	0 0	7. Hospital License (It is the responsibility of the provider to keep updated licensure information on file with the state by		
S	<u> </u>	submitting a copy of the license to provider enrollment each time it is renewed)		

red	<b>7. Hospital License</b> (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)						
<u>.</u>	License #	Issued:		Expires:			
e O							
Ř	8. NPI prinout from the NPPES Website					NPPES Website	

8. NPI prinout from the N	NPPES Website			
9. <u>SFN 661 (12-2022)</u>	Printed Name of Signing Managing Employee:		SFN 661 (12-2022)	

Must match the Information provided on the SFN 661

9a. Bank Letter/Voided Check

12. SFN 615 (6-2023)

10. Claim (Required if you answered Yes to question 3 above) Claims submitted are for Enrollment Purposes Only

Printed Name of Signing Managing Employee:

11. <u>SFN 1168 (8-2020)</u>	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.		

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	027- Hospital Units			
	SPECIALTY	196-Swingbed			
	TAXONOMY	275N00000X			
Section 4: Enrollment Effective Date	enrollment effective application is app effective date will de days* prior to the d requested is outside from the date the co *If this application is assoc complete application pack This application is Requested Enrollment E Printed Name of Person Requesting the Effective Date	date. <b>The Depar</b> <b>roved</b> and any cla eny. A retroactive ate a <b>complete</b> a the 90 day timef omplete applicatio iated with an emergence et is received. You must associated with an eme ffective Date	rtment will not ma laims submitted with e enrollment effective application packet is frame, the enrollmen on packet was receive cy service, the Department r it include a copy of the claim	ke changes to a date of service date is limited to received by the section of the date ed. may consider a date m and medical records puesting the date of Date	rea to determine the correct <b>that date once the</b> the prior to the enrollment to no more than ninety (90) Department. If the date assigned will be 90 days more than 90 days prior to the date a twith your application documents. 

#### 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. <u>Click Here</u> for the hospital professional billing checklist.

Have Questions?					
Click Here for FAQs and More Resources					

	Application Tracking #								
_	Provider Name								
Section 1: dentifying Information	Organizational NPI #								
nat									
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Section 1: ying Inforr	Billing Address	_							
ect ng	Mailing Address								
Scifyi	Facility Phone								
ent	-								
Id	Contact Person								
	Phone								
	Email								
					Madiana Franklin	and to us outline d	l		
	1. Are you Enrolled in Me Please Provide	your Medicare ID:		L YES	Medicare Enrollm	ent is required			
	Is your Medicare Re	-			□ YES				
	2. Are you Enrolled in Me	edicaid in another	State?			☐ YES			
	State Abbv:		State:	Please P	rovide your Other Sta				
	3. Are you enrolling any				e at this time? ses of all service loca	tions being enro	VES	NO In the same	
					ses of all service loca	tions being ento	lieu (inust nave	the same	
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Page 2	2 of 3
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		10. Does the enrolling facility provide residential or inpatient services to individuals with mental disease Mental diseases are diseases listed as mental disorders in the International Classification of Diseases (ICI with the exception of intellectual disability, senility and organic brain syndrome. Substance use disorder are considered a mental disease. If Yes, answer questions 10a-10e below.	D),	] Yes		No
Section 2: Questions	tinued	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 mo than one bed, each bed must be counted.)	e			
	Cont	10b. Does your facility have specific beds or units that are allocated for services for individuals with mental diseases?		Yes		No
Sec		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		Yes		No
		diseases? If yes, provide a list with the addresses of each location.				
		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.	н	elpful Links	Su	bmitted
		Outdated versions of forms will not be accepted.		versheet for	⊢	
		1. <u>Coversheet for Fax/Email</u>		Fax/Email		
		2. Group Application Checklist			Г	
		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)	Г	
				5 (10 2020)		
	ents	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	-	What is the P575/147C?		
on 3:	Docume	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.		ax Exempt Letter r Government Agencies		
Section		7. Hospital License (It is the responsibility of the provider to keep updated licensure information on file with the state by			г	
Se	quired	submitting a copy of the license to provider enrollment each time it is renewed)				
	nba	License # Issued: Expires:				
	Re	8. CLIA (If applicable)				
	ļ					
		9. NPI prinout from the <u>NPPES Website</u>	<u>NP</u>	PES Website		
		10. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	SFN	<b>1 661 (12-2022</b> )		
		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. <u>SFN 1168 (8-2020)</u>	Instr	Simplified uctions based or FAQs	1	
		12a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs			Γ	
		12b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.			Γ	
					-	
		13. SFN 615 (6-2023)       Printed Name of Signing Managing Employee:		<u>N 615 (6-2023)</u>	L	
		Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be d	eleteo	d from the file. It	rem	ains 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     028-Hospitals							
	SPECIALTY							
	TAXONOMY							
	What is a Taxonomy? Click Here to find more information on Taxonomies							
/e Date	Already Know your Taxonomy? Click here to find out which Pro https://www.hhs.nd.gov/sites/www/files/documents/DHS%201							
Section 4: Taxonomy & Enrollment Effective Date	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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.							
Taxonomy 8	*If this application is associated with an emergency service, the Departmer complete application packet is received. You must include a copy of the cla This application is associated with an emergency service. We are r Requested Enrollment Effective Date	im and medical records with y	our application documents.					
	Printed Name of Person Requesting the Effective Date	Date						
	Click Here to find more information on Effective I	Dates and Retro Effective Da	ate Policies					

Revision

8/22/2023

#### 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. <u>Click Here</u> for the institutional billing checklist.

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #							
	Provider Name							
ation	Organizational NPI #							
Section 1: Identifying Information	Service Address							
on Infe	Billing Address							
Section 1: ying Inforr	Mailing Address							
S. ifyi	Facility Phone							
ent								
Ide	Contact Person							
	Phone							
	Email							
Section 2: Questions		If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been pr e Provider (Service f the claim for the nt documents. The FEDERAL taxes? duals or Businesse r indirect) Employees (author oyees, attach a list as	ude a list with the addre PI, EIN, and billing addre addresses located within Nord cout of state service location rovided at each location. e location more than 50 service that was provice date of service on the of yES NO es which have 5% or mo	esses of all service locati ess). In Dakota and bordering citie s. Out of state service location miles from the North D led to an eligible ND Me claim must support your If Exempt from FEDERA re interest in the enrolli f the business) do you h	s (within 50 miles of ons will only be enrol akota border?) edicaid Recipient requested effect AL Taxes, submit you ng group?	the ND bo led in an must b tive dat	order) cannot b out of state rec YES e submitted e for enrollm	e enrolled ord if NO with ient.
	6. Are you organized as a corporation?	6a. If Yes, how ma If more than 3 Board	n-profit corporation, or any Board Members do Members, attach a list as pa	you have?	rganized as a		YES	□ NO
	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.						inter Initials uired for enr	

		The documents requested	d below must be r	eturned to the	e Department i	n order to process	your enrollmen	t	
		Please ensure you use the	•		irrent versions	of each form.		Helpful Links	Submitted
		Outdated versions of form 1. Coversheet for Fax/Em		epted.				Coversheet for	
		Fax/Email							
		2. Group Application Che	ecklist						
		3. List of Service Location	s (Required if you	answered Yes	to question 1	above)			
		4. W-9 (10-2018)	Printed Name of Si	igning Managing	g Employee:			<u>W-9 (10-2018)</u>	
								What is the	
	ents	5. CP 575/147C (Not requ	iired if submitting	a FEDERAL tax	exempt lette	r issued by the IRS)		<u>CP575/147C?</u>	
Э: Э:		6. IRS Tax Exempt Letter	(Required if you a	nswered Yes to	o question 3 at	ove)		IRS Tax Exempt Letter	
	Docum		If Exempt from FEDEF cannot be substitute		•	ax Exempt Letter. A Sta IRS.	ate issued letter	for Government Agencies	
Section		7. License. License must k	pe from one of you	ur MD practitic	oners, must co	ver the effective da	ate below, and		
Š	uired	must not be expired. License #		Issued:		Expires:			
	Req					•			
	ш.,	8. NPI prinout from the <u>N</u>	IPPES Website					<u>NPPES Website</u>	
		9. <u>SFN 661 (12-2022)</u>	Printed Name of Si	igning Managing	g Employee:			<u>SFN 661 (12-2022)</u>	
		9a. Bank Letter/Voi	ded Check	Must match th	e Information p	rovided on the SFN 6	661		
		10. Claim (Required if you	u answered Yes to	question 2 ab	ove) <mark>Claims sub</mark> r	nitted are for Enrollme	nt Purposes Only		
								Simplified	
		11. <u>SFN 1168 (8-2020)</u>						Instructions based on <u>FAQs</u>	
		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. <u>SFN 615 (6-2023)</u>	Printed Name of Si	gning Managing	; Employee:			SFN 615 (6-2023)	
		Proof of Insurance is not rec provider's responsibility to							
		PROVIDER TYPE	026-	Ambulatory H	lealth Care Fac	ilities			
	ate	SPECIALTY/Taxonomy (Please Choose One)	503-Single S 1934000			lti-Specialty 200000X			
Section 4:	' & Enrollme	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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.							
	axonomy	Printed Name of Person Requesting the				Date			
	Тах	Effective Date	lere to find more	information or	1 Effective Dat	Date	ive Date Policies		

8/22/	2023

#### Group Application Checklist Laboratory (029)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #							
	Provider Name							
ion	Organizational NPI #							
Section 1: Identifying Information		<u> </u>						
1: orn	Service Address							
ion Inf		Only 1 service locat	ion may be en	rolled per Medio	aid ID.			
Section ying Info	Billing Address							
Scifyi	Mailing Address							
ent	Facility Phone							
Ide	Contact Person							
	Phone							
	Email							
	Ellidii							
	1. Are you Enrolled in M	edicare?		□ YES		1		
	-	your Medicare ID:						
	Is your Medicare Re	ecord up to date?			□ YES			
	2. Are you Enrolled in M	odicaid in another	State?			- □ YES		
	2. Are you Enroned in Wi		State	Please Pro	Divide your Other Sta			
					-			
	3. Are you exempt from	FEDERAL taxes?	☐ YES		If Exempt from FEDER	AL Taxes, submit yo	ur I <mark>RS</mark> issued Tax Exempt	Letter.
	4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?							
2: ns	(Interest may be direct o	or indirect)						
	5. How many Managing					have?		
Section Questio	If more than 3 Managing Emp List must contain First Names				8 (page 2).			
Se QL	6. Are you organized as a	cornoration a no	n-profit corp	oration or a g	overnment agency (	organized as a		
	corporation?	•					☐ YES	
		6a. If Yes, how ma If more than 3 Board		-				
		1168 (page 2).						]
	The documents requeste			-	-	s your enrollment	:	1
Its	Please ensure you use th Outdated versions of for			current version	s of each form.		Helpful Links	Submitted
							Coversheet for	
Jer	1. Coversheet for Fax/En	nail					Fax/Email	
3: cuments							Fax/Email	
3: CU	2. Group Application Che						Fax/Email	
3: CU	2. Group Application Che		gning Managi	ng Employee:			Fax/Email <u>W-9 (10-2018)</u>	
Section 3: ired Docu	2. Group Application Che 3. <u>W-9 (10-2018)</u>	ecklist Printed Name of Si					<u>W-9 (10-2018)</u>	
section 3: red Docu	<ul> <li>2. Group Application Che</li> <li>3. <u>W-9 (10-2018)</u></li> <li>4. CP 575/147C (Not required)</li> </ul>	ecklist Printed Name of Si			er issued by the IRS)	)		

Ъ	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						
3: nts Continue	6. 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:							
Section								
Sec	8. NPI prinout from the <u>NPPES Website</u>	NPPES Website						
Ц С	9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>						
uired	9a. Bank Letter/Voided Check Must match the Information provided on the SFN 661							
Redu	10. <u>SFN 1168 (8-2020)</u>	Simplified Instructions based on <u>FAQs</u>						
	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:	<u>SFN 615 (6-2023)</u>						
	Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to b							
	<b>PROVIDER TYPE</b> 029-Laboratories	be submitted for any ap						
	SPECIALTY							
ate	ΤΑΧΟΝΟΜΥ							
	What is a Taxonomy? Click Here to find more information on Taxonomies							
Effective	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							
Ľ.	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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: nrollment	<b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department. requested is outside the 90 day timeframe, the enrollment effective date assigned will	e enrollment an ninety (90) If the date						
Section 4: & Enrollment	<b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department. requested is outside the 90 day timeframe, the enrollment effective date assigned will	e enrollment han ninety (90) If the date be 90 days						
Section 4: & Enrollment	<b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department. requested is outside the 90 day timeframe, the enrollment effective date assigned will from the date the complete application packet was received.	e enrollment an ninety (90) If the date be 90 days s prior to the date a ation documents.						
Section 4: Enrollment	<b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department, requested is outside the 90 day timeframe, the enrollment effective date assigned will 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 complete application packet is received. You must include a copy of the claim and medical records with your application.         This application is associated with an emergency service. We are requesting the date of	e enrollment an ninety (90) If the date be 90 days s prior to the date a ation documents.						
Section 4: & Enrollment	<b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more the days* prior to the date a <b>complete</b> application packet is received by the Department. requested is outside the 90 day timeframe, the enrollment effective date assigned will 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 complete application packet is received. You must include a copy of the claim and medical records with your application.	e enrollment han ninety (90) If the date be 90 days s prior to the date a ation documents. Refer to the * above.						

Skilled Nursing Facility (031 - 269)

Have Questions?

Click Here for FAQs and More Resources

Provider Name		Application Tracking #							
Billing Address       Mailing Address         Hailing Address       Facility Phone         Contact Person       Phone         Email       Contact Person         Phone       Email         I. Are you Enrolled in Medicare?       NO         V Bease Provide your Medicare ID:       Is your Medicare Record up to date?         Is your Medicare Record up to date?       NO         2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES         Source Train       If exempt from FEDERAL taxes?         4. Do you have any Individuals or Businesses which have 5% or more Interest in the enrolling group?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       It must contain First Names, Last Abanes, bate of Birth, and StMS       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       YES       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an a terred on denies for processing. The "insteading is network on the accepted.       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an attending be enrolled on the cloim, or t		Provider Name							
Billing Address       Mailing Address         Hailing Address       Facility Phone         Contact Person       Phone         Email       Contact Person         Phone       Email         I. Are you Enrolled in Medicare?       NO         YES       NO         Is your Medicare Record up to date?       NO         Is Are you and out of State Provider (Service location more than 50 miles from the North Dakota       ves         Is Are you ano Dut of State Provider (Service location more than 50 miles from the North Dakota       ves         A. Do you have any Individuals or Businesses which have 5% or more Interest in the enrolling group?       yes       NO         St. How many Managing Employees (authorized to sign on behalf of the business) do you have?       Hmore than 3 Managing Employees (authorized to sign on behalf of the business) do you have?       It must contain First Nmms, Last Name, Date of Sith Sith Sith Sith Sith Sith Sith Sith	1: ormation	Organizational NPI #							
Billing Address       Mailing Address         Hailing Address       Facility Phone         Contact Person       Phone         Email       Contact Person         Phone       Email         I. Are you Enrolled in Medicare?       NO         V Bease Provide your Medicare ID:       Is your Medicare Record up to date?         Is your Medicare Record up to date?       NO         2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES         Source Train       If exempt from FEDERAL taxes?         4. Do you have any Individuals or Businesses which have 5% or more Interest in the enrolling group?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       It must contain First Names, Last Abanes, bate of Birth, and StMS       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       YES       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an a terred on denies for processing. The "insteading is network on the accepted.       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an attending be enrolled on the cloim, or t									
Billing Address       Mailing Address         Hailing Address       Facility Phone         Contact Person       Phone         Email       Contact Person         Phone       Email         I. Are you Enrolled in Medicare?       NO         V Bease Provide your Medicare ID:       Is your Medicare Record up to date?         Is your Medicare Record up to date?       NO         2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES         Source Train       If exempt from FEDERAL taxes?         4. Do you have any Individuals or Businesses which have 5% or more Interest in the enrolling group?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       It must contain First Names, Last Abanes, bate of Birth, and StMS       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       YES       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an a terred on denies for processing. The "insteading is network on the accepted.       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an attending be enrolled on the cloim, or t		Service Address							
Billing Address       Mailing Address         Hailing Address       Facility Phone         Contact Person       Phone         Email       Contact Person         Phone       Email         I. Are you Enrolled in Medicare?       NO         V Bease Provide your Medicare ID:       Is your Medicare Record up to date?         Is your Medicare Record up to date?       NO         2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES         Source Train       If exempt from FEDERAL taxes?         4. Do you have any Individuals or Businesses which have 5% or more Interest in the enrolling group?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       It must contain First Names, Last Abanes, bate of Birth, and StMS       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       YES       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an a terred on denies for processing. The "insteading is network on the accepted.       NO         7. What is the name and Medicatel D). Application Tracking Number, or NPI of the medical director or attending physician which will be on your claims? (Institutioni claims required an attending be enrolled on the cloim, or t	on Infc		Only 1 service locat	ion may be enrolled per Medic	aid ID.				
Facility Phone     Facility		Billing Address							
Contact Person       Phone         Email       Email         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 an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         3. Are you exempt from FEDERAL taxes?       YES       NO       YES       NO         3. Are you exempt from FEDERAL taxes?       YES       NO       YES       NO         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       Interest may be direct or indirect)       NO         5. How many Managing Employees attach a list as part of Section III of the SFN 1168 (page 2).       It more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       It more than 3 Managing Employees, 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 broked and methered on dating for processing. The "ottending" can be either a medicaid director or attending be conjuled and network on dating for processing. The "ottending" can be either a medicaid director or attending is not enrolled, the claim will deny.)         No       No       YES <td>Se fyir</td> <td>Mailing Address</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Se fyir	Mailing Address							
Contact Person       Phone         Email       Email         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 an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         3. Are you exempt from FEDERAL taxes?       YES       NO       YES       NO         3. Are you exempt from FEDERAL taxes?       YES       NO       YES       NO         4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       Interest may be direct or indirect)       NO         5. How many Managing Employees attach a list as part of Section III of the SFN 1168 (page 2).       It more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       It more than 3 Managing Employees, 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 broked and methered on dating for processing. The "ottending" can be either a medicaid director or attending be conjuled and network on dating for processing. The "ottending" can be either a medicaid director or attending is not enrolled, the claim will deny.)         No       No       YES <td>enti</td> <td>Facility Phone</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	enti	Facility Phone							
Phone       Email         I. 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         I. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         I. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota       YES       NO         I. 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?       YES       NO         Interest may be direct or indirect)       S. How many Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).         Is throw organized as a corporation, a non-profit corporation, or a government agency organized as a Corporation or allow of allowed proves the endered of claims for processing. The "ottending" can be there a medical first (page 2).         Is 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 on entending be enrolled and nertee on claims for processing. The "ottending" can be there a me	lde								
Email         Image: Section 10 and 10 a		Contact Person							
Image: State Provide description of the set of		Phone							
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       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?       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).       If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       So. If Yes, how many Board Members do you have?       NO         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:         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. <td></td> <td>Email</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		Email							
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       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?       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).       If more than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation?       So. If Yes, how many Board Members do you have?       NO         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:         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. <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
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       YES       NO         3. Are you exempt from FEDERAL taxes?       VES       NO       If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.         3. Are you exempt from FEDERAL taxes?       VES       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?       YES       NO         5. How many Managing Employees (authorized to sign on behalf of the business) do you have?       If more than 3 Managing Employees (authorized to sign on behalf of the business) do you have?       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a       YES       NO         6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a       YES       NO         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 on attending is included on the claim, or the attending is on teanolled, the claim will deny.) Name:       Medicaid ID/ATN/NPI:         The documents requested below must be returned to the Department in order to processing. The "attending " can be either a medical direct or attending/referring doctor. If no attending is included on the claim, or the		-			Medicare Enrollmo	ent is required			
2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota     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? YES NO     If Linerest may be direct or indirect)     Solution     S		-							
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?       YES       NO         9000000000000000000000000000000000000		Is your Medicare Re	cord up to date?		L YES				
4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? YES NO   4. Do you have any Individuals or Businesses which have 5% or more interest in the enrolling group? YES NO   4. How many Managing Employees (authorized to sign on behalf of the business) do you have? For them a Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2). 6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? 6. Are you organized as a corporation, a non-profit corporation, or a government agency organized as a corporation? 6. 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 determing dotor. If no attending is included on the claim, or the attending is not enrolled, the claim will deny.) Name: 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. Unitable Versions of forms will not be accepted. 1. Coversheet for Fax/Email 2. Goversheet for Fax/Email 2. Goversheet for Fax/Email 2. Goversheet for Fax/Email 2. Goversheet for Fax/Email 3. Goversheet			e Provider (Service	e location more than 50 mil	es from the North D	Dakota	☐ YES	□ NO	
Coupyon       (Interest may be direct or indirect)       VES       NO         Interest may be direct or indirect)       S. How many Managing Employees (authorized to sign on behalf of the business) do you have?       Imore than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).       Imore than 3 Managing Employees, attach a list as part of Section III of the SFN 1168 (page 2).         Is 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?       Imore than 3 Board Members do you have?       NO         Ga. 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       NO         Its (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:       Name:       Medicaid ID/ATN/NPI:         The documents requested below must be returned to the Department in order to process your enrollment       Helpful Links       Submitted         Outdated versions of forms will not be accepted.       1. Coversheet for Fax/Email       Coversheet for Fax/Email       Coversheet for Fax/Email		3. Are you exempt from FEDERAL taxes? I YES I NO If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.							
Solution       Interview of the state and solution of th	2 N			es which have 5% or more ir	terest in the enroll	ing group?	□ YES	□ NO	
Corporation?       Ga. 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:         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.         1. Coversheet for Fax/Email         2. Group Application Checklist	Sectio Quest	If more than 3 Managing Empl	oyees, attach a list as l	part of Section III of the SFN 1168		ave?			
Ga. 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:         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.         1. Coversheet for Fax/Email         2. Group Application Checklist			corporation, a no	n-profit corporation, or a g	overnment agency o	organized as a	□ YES	□ NO	
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: 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. 1. Coversheet for Fax/Email 2. Group Application Checklist			If more than 3 Board						
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted. 1. Coversheet for Fax/Email 2. Group Application Checklist		your claims? (Institutional director or attending/refer	essing. The "atte	nding" can be either a i					
Please ensure you use the links provided to obtain the current versions of each form. Outdated versions of forms will not be accepted. 1. Coversheet for Fax/Email 2. Group Application Checklist					-				
	S	-		-	-	your enrollmen			
	3: ument				s of each form.			Submitted	
	e tion d Doc	1. <u>Coversheet for Fax/Em</u>	ail						
	Se equire	2. Group Application Che	cklist						
	ž	3. <u>W-9 (10-2018)</u>	Printed Name of Sig	gning Managing Employee:			<u>W-9 (10-2018)</u>		

		4. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)						<u>What is the</u> <u>CP575/147C?</u>	
	ued	5. IRS Tax Exempt Letter	IRS Tax Exempt Letter for Government Agencies						
	ntin	6. Nursing Facility License state by submitting a copy of					n file with the		
	S	License #	ŧ	Issued:		Expires:			
 	nts	7. CLIA							
Section	nei	License #	ŧ	Issued:		Expires:			
Scti	nu								
S	Doc	8. NPI prinout from the	NPPES Website					NPPES Website	
		9. <u>SFN 661 (12-2022)</u>	Printed Name of Si	igning Managing	g Employee:			SFN 661 (12-2022)	
	uired	9a. Bank Letter/Vo	ided Check	Must match th	e Information p	provided on the SFN 6	661		
	σ				-				
	Re	10. <u>SFN 509 (5-2021)</u>	(Required for Out of Date of service must on the Medical Note	match the enroll		question 2 above) ate below and match th	e date of service	<u>SFN 509 (5-2021)</u>	
		10a. Copy of Claim	(Required for Out of Claims submitted ar			question 2 above)			
		10b. Medical Notes	(Required for Out of	State providers =	Answered yes to				
			Medical Notes subm	nitted are for Enro	ollment Purposes	s Only.			
		11. <u>SFN 1168 (8-2020)</u>						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.							
				Jection III (Fag	se zj with dates				
		12. <u>SFN 615 (6-2023)</u>	Printed Name of Si	igning Managing	g Employee:			<u>SFN 615 (6-2023)</u>	
		Proof of Insurance is not re provider's responsibility to							
		PROVIDER TYPE	031-Nursing & Cust	todial Care Facili	ities				
		SPECIALTY	269-Skilled Nursing	g Facility					
		TAXONOMY	31400000X						
4: ective Date		Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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 Eff	*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.							
	č	Requested Enrollmont Effective Date							
	Enro	Requested Enrollment Ef	ffective Date		]				
	Enro	Printed Name of Person Requesting the				Date			
	Enro	Printed Name of Person Requesting the Effective Date		information o	n Effective Dat	Date tes and Retro Effect	tive Date Policie	<u>-5</u>	

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

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #								
Section 1: Identifying Information	Provider Name								
	Organizational NPI #								
nat									
1: orr	Service Address								
ion Inf		Only 1 service locat	ion may be enrol	lled per Medic	aid ID.				
Section ying Info	Billing Address								
S ifyi	Mailing Address								
ent	Facility Phone								
ld	Contact Person								
	Phone								
	Email								
	1. Are you Enrolled in Me	edicare?		☐ YES		1			
	Please Provide y	your Medicare ID:							
	Is your Medicare Re	cord up to date?			□ YES				
	2. Are you Enrolled in Me	edicaid in another	State?		□ NO	☐ YES			
	State Abbv:			Please Pro	ovide your Other St	ate Medicaid ID:			
	3. Are you an Out of Stat	e Provider (Service	e location more	e than 50 mi	es from the North I	Dakota			_
	border?)							YES	
	4. Are you exempt from FEDERAL taxes? I YES I NO If Exempt from FEDERAL Taxes, submit your IRS issued Tax Exempt Letter.								
Section 2: Questions	5. Do you have any Indivi (Interest may be direct o		es which have 5	5% or more i	nterest in the enroll	ing group?		YES	□ NO
Section 2 Question	6. How many Managing E	Employees (author	ized to sign on	behalf of th	e business) do vou ł	nave?			
Sec Qu	If more than 3 Managing Empl List must contain First Names,	oyees, attach a list as	part of Section III o						
	7. Are you organized as a corporation?	a corporation, a no	n-profit corpor	ration, or a g	overnment agency	organized as a		YES	
		7a. If Yes, how ma If more than 3 Board 1168 (page 2).	-	-					
		1100 (page 2).							
	8. What is the name and on your claims? (Institutio director or attending/refer	onal claims require a		-					
	Name:			Medicai	d ID/ATN/NPI:				
3: Its	The documents requeste			-	-	s your enrollmen	t		
	Please ensure you use th Outdated versions of for			rrent versior	is of each form.		Не	lpful Links	Submitted
Section Required Documer								versheet for ax/Email	

		2. Group Application Ch	ecklist									
		3. <u>W-9 (10-2018)</u>	Printed Name of Si	igning Managin	g Employee:			<u>W-9 (10-2018)</u>				
		4. CP 575/147C (Not req	uired if submitting	a FEDERAL ta	x exempt lette	r issued by the IRS		<u>What is the</u> <u>CP575/147C?</u>				
	ned	5. IRS Tax Exempt Letter	• • •	RAL Taxes, submi	it your I <mark>RS</mark> issued	Tax Exempt Letter. A S	tate issued letter	IRS Tax Exempt Letter for Government Agencies				
	Continued	6. PRTF License (It is the resubmitting a copy of the license #	se to provider enrollme			ormation on file with the	e state by					
 	Its											
	len	7. Accreditation										
Section	cum	8. NPI prinout from the [	NPPES Website					NPPES Website				
S	DO											
	ba	9. <u>SFN 661 (12-2022)</u>	Printed Name of Sig					<u>SFN 661 (12-2022)</u>				
	luired	9a. Bank Letter/Vo	ided Check	Must match th	e Information p	provided on the SFN 6	561					
	Redu	10. <u>SFN 509 (5-2021)</u>	(Required for Out of Date of service must		-	-		<u>SFN 509 (5-2021)</u>				
		10a. Copy of Claim	(Required for Out of			question 3 above)						
	]		Claims submitted are	e for Enrollment	Purposes Only.							
		11. <u>SFN 1168 (8-2020)</u>						Simplified Instructions based on				
		11a. List of Managir	ng Employees attach	ed to Section III	(Page 2) with d	ates of birth and SSN	ls	FAQs				
		11b. List of Board N	1embers attached to	Section III (Pag	e 2) with dates	of birth and SSNs.						
		12. <u>SFN 615 (6-2023)</u>	Printed Name of Si	igning Managin	g Emloyee:			<u>SFN 615 (6-2023)</u>				
		Proof of Insurance is not re provider's responsibility to PROVIDER TYPE		essary insuranc	e is in place, bu							
		SPECIALTY	258-Psychiatric Res									
			323P00000X		entracinty							
				-								
	tive Date	Please coordinate w enrollment effective <b>application is app</b> effective date will de days* prior to the d requested is outside from the date the co	e date. The Dep roved and any eny. A retroactiv ate a complete e the 90 day tim	claims sub ve enrollme e application eframe, the	vill not ma mitted with nt effective n packet is e enrollment	ke changes to a date of servic date is limited received by the effective date a	that date o the prior to the to no more the Department.	nce the e enrollment an ninety (90) If the date				
Section 4:	t Effective	*If this application is assoc complete application pack	•	•	•	•	•	•				
Se	nrollment	This application is	s associated with an	emergency serv	vice. We are req	uesting the date of		Refer to the * above.				
	rolli	Requested Enrollment E	ffective Date									
	Eni	Printed Name of Person Requesting the Effective Date				Date						
			Here to find more	information o	n Effective Dat	tes and Retro Effect	tive Date Policie	S				
		Revision	8/22/2023									

## Group Application Checklist QRTP (032 - 264)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #									
		Provider Name									
	ion	Organizational NPI #									
	Identifying Information										
1:	or	Service Address									
Section	Inf		Only 1 service locati	on may be enrolle	ed per Medica	id ID.					
ect	ing	Billing Address									
S	tify	Mailing Address									
	len.	Facility Phone									
	0	Contact Person									
		Phone									
		Email									
		1. Are you Enrolled in Me		□ NO	T YES						
		Please Provide y Is your Medicare Re	your Medicare ID:			□ YES					
		is your medicare ne									
		2. Are you Enrolled in Mo		State?		ΝΟ	☐ YES				
		State Abbv:			Please Prov	vide your Other Sta	te Medicaid ID:				
		3. Are you an Out of Stat	e Provider (Service	e location more	than 50 mile	s from the North D	akota		YES		NO
		border?) If yes, a copy o	of the claim for the	service that wa	s provided to	an eligible ND Me	dicaid Recipient	t must b	e submit	Led with	
		your enrollme	nt documents. The	date of service	on the claim	must support your	requested effect	tive da	te for enr	ollment.	
		4. Are you exempt from	FEDERAL taxes?	□ YES		If Exempt from FEDER/	AL Taxes, submit yo	ur <mark>IRS</mark> iss	ued Tax Exe	empt Lette	·.
5.	SUC	5. Do you have any Indivi	duals or Businesse	s which have 59	% or more int	erest in the enrolli	ng groun?				
Section	estio	(Interest may be direct o					ing Brook:		YES		NO
ect	Sue	6. How many Managing E	- mployees (author	ized to sign on k	pehalf of the	business) do vou h	ave?				
S	0	If more than 3 Managing Empl	loyees, attach a list as	part of Section III o							
		List must contain First Names									
		7. Are you organized as a corporation?	corporation, a no	n-profit corpora	ation, or a go	vernment agency o	organized as a		YES		NO
			7a. If Yes, how ma If more than 3 Board	-	-						
			1168 (page 2).	Weinbers, attach t							
		I have read and acknowl	edge that I unders	tand the follow	ing: Affiliatio	ns (separate indivi	dual		Enter Init	ials belov	N
		enrollments) are require etc.) and the individual r		-	-		· •	(red	quired for	r enrollm	ent)
		must be linked ("affiliate	ed") to the billing p	rovider record i	in the system	. For all rendering	providers who				
		are not actively enrolled application is approved.	in ND Medicaid, ir	ndividual applic	ations should	l be submitted bef	ore the group				

Page 2 of 2
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		The documents requeste	d below must be r	eturned to the	e Department	in order to process	your enrollmen	t				
		Please ensure you use th	e links provided to	o obtain the c	urrent version	s of each form.			Culture Harris			
		Outdated versions of for	ms will not be acce	epted.				Helpful Links	Submitted			
		1. Coversheet for Fax/Em	nail					Coversheet for				
								Fax/Email				
		2. Group Application Che	ecklist									
		3. <u>W-9 (10-2018)</u>	Printed Name of Si	gning Managing	g Employee:			<u>W-9 (10-2018)</u>				
	b											
	U	4. CP 575/147C (Not req	uired if submitting	a FEDERAL ta	x exempt lette	er issued by the IRS)		What is the				
	Continue				•			<u>CP575/147C?</u>				
	Ċ	5. IRS Tax Exempt Letter	(Required if you a	nswered Yes t	o question 4 a	bove)		IRS Tax Exempt Letter				
	ŭ		• • •		•	Tax Exempt Letter. A St	ate issued letter	for Government				
.: .:	ts			<u>Agencies</u>								
	en	6. QRTP License (It is the responsibility of the provider to keep updated licensure information on file with the state by										
Section	ocume	submitting a copy of the licens										
eC	C	License #	ŧ	Issued:		Expires:						
S	<b>0</b>											
	q	7. NPI prinout from the	NPPES Website					NPPES Website				
	equire											
		8. <u>SFN 661 (12-2022)</u>	Printed Name of Si	<mark>gning Managin</mark>	g Employee:			<u>SFN 661 (12-2022)</u>				
	e	8a. Bank Letter/Vo	ided Check	Must match th	e Information p	provided on the SFN 6	61					
	2											
		9. Claim (Required if you	answered Yes to a	question 3 abc	ove) Claims subm	nitted are for Enrollmen	t Purposes Only					
		10 (51) (1(0) (0, 2020)						Simplified Instructions based on				
		10. <u>SFN 1168 (8-2020)</u>						FAQs				
		10a. List of Managi	ng Employees attac	hed to Section I	III (Page 2) with	dates of birth and SS	Ns					
		10b. List of Board N	Members attached t	o Section III (Pa	ge 2) with dates	s of birth and SSNs.						
				•	<u> </u>							
		11. <u>SFN 615 (6-2023)</u>	Printed Name of Si	gning Managin	g Employee:			SFN 615 (6-2023)				
		Proof of Insurance is not re	quired for any applic	cation. If proof o	of insurance is su	ubmitted with an app	lication, it will be	deleted from the file. It	remains the			
		provider's responsibility to	ensure that the neo	cessary insurand	ce is in place, bu	it proof of insurance i	s not required to	be submitted for any a	pplication.			
		PROVIDER TYPE	032-Residential Tre	atment Facilitie	S							
		SPECIALTY	264-QRTP, Qualifie			m						
		TAXONOMY	322D00000X									
			322D00000X									
		Please coordinate wi	ith your billing	department	and any ot	her applicable a	rea to detern	nine the correct				
	Ð	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										
	ate	application is app										
		effective date will de										
	Effective	days* prior to the days* prior to the days* prior to the days and the days and the days are days ar										
4:	5	from the date the co					ussigned win	be 90 days				
Section 4:	ffe								•			
t:	ш	*If this application is assoc	iated with an emerg	ency service, th	ne Department i	may consider a date r	nore than 90 days	prior to the date a				
e	int	complete application pack	et is received. <mark>You m</mark>	nust include a co	opy of the claim	and medical records	with your applica	tion documents.				
S	me	This application is	associated with an	emergency serv	vice. We are req	uesting the date of		Refer to the * above.				
					_							
	nrol	Requested Enrollment Ef	fective Date		]							
		Printed Name of Person	<b>I</b>						1			
		Requesting the				Date						
		Effective Date										
			Here to find more	information o	n Effective Da	tes and Retro Effect	ive Date Policie	<u>s</u>				
		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 322D0000X) so you can bill services provided by non-OLPs.

<u>Click Here</u> for the regular QRTP checklist.

### Have Questions? Click Here for FAQs and More Resources

	Application Tracking #				
_	Provider Name				
on 1: Information	Organizational NPI #				
at					
1: T	Service Address				
on Infc	Billing Address				
	Mailing Address				
Sect Identifying	Facility Phone				
bt I					
de	Contact Person				
	Phone			 	
	Email				

	1. Are you enrolling any additional service locations not listed above at this time?		YES	
	If yes, please include a list with the addresses of all service locations being enrol Provider Type, NPI, EIN, and billing address). Please note: Service addresses located within North Dakota and bordering cities (within 50 miles o in the same record as out of state service locations. Out of state service locations will only be enro services have been provided at each location.	f the ND b	oorder) canno	ot be enrolled
	2. Are you an Out of State Provider (Service location more than 50 miles from the North Dakota border?)		YES	
	If yes, a copy of the claim for the service that was provided to an eligible ND Medicaid Recipien your enrollment documents. The date of service on the claim must support your requested effe			
	3. Are you exempt from FEDERAL taxes?  YES  NO If Exempt from FEDERAL Taxes, submit you	our <mark>IRS</mark> iss	ued Tax Exen	npt Letter.
on 2: tions	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
Section 2 Question	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	
	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 Initia quired for e	als below enrollment)

		The documents requeste	d below must be re	eturned to the	e Department	in order to process	your enrollmen	t			
		Please ensure you use th Outdated versions of form	-		urrent version	s of each form.		Helpful Links	Submitted		
		1. <u>Coversheet for Fax/Em</u>						Coversheet for Fax/Email			
		2. Group Application Che	ecklist								
		3. List of Service Location	ns (Required if you	answered Yes	s to question 1	above)					
		4. W-9 (10-2018)	Printed Name of Sig	gning Managing	g Employee:			W-9 (10-2018)			
	ts	5. CP 575/147C (Not requ	uired if submitting	a FEDERAL tax	x exempt lette	r issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>			
	nen	6. IRS Tax Exempt Letter			•	•		IRS Tax Exempt Letter			
n 3:	ocuments		If Exempt from FEDER cannot be substituted			Tax Exempt Letter. A St e <mark>IRS</mark> .	ate issued letter	for Government Agencies			
Section		7. License. License must below, and must not be e		r rendering pr	ractitioners, m	ust cover the effec	tive date				
Sec	ired	License #	-	Issued:		Expires:					
	edu	8. NPI prinout from the N	IPPES Website					NPPES Website			
	Ř	9. SFN 661 (12-2022)	Printed Name of Sig	ning Managing	g Employee			SFN 661 (12-2022)			
		9a. Bank Letter/Voi				provided on the SFN (	661	5111 001 (12 2022)			
		10. Claim (Required if you	u answord Vos to	auostion 2 ab	ovo) Claims sub	mitted are for Encolling	ant Durnosos Only				
			u alisweleu tes lo	question 2 ab	ove) claims sub	mitted are for Enrollme	ent Purposes Only	Simplified			
		11. <u>SFN 1168 (8-2020)</u>						Instructions based on FAQs			
		11a. List of Managin	g Employees attache	ed to Section III	(Page 2) with d	ates of birth and SSN	ls				
		11b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.									
		12. <u>SFN 615 (6-2023)</u>	Printed Name of Sig	ning Managing	g Employee:			<u>SFN 615 (6-2023)</u>			
		Proof of Insurance is not rec provider's responsibility to o									
		PROVIDER TYPE	026- Ambulatory	Health Care Fa	acilities						
	b	SPECIALTY	504-Multi-Specialt	У							
	Date	ΤΑΧΟΝΟΜΥ	193200000X								
4:	Effective	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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	**If this application is assoc complete application packe This application is	et is received. You m	ust include a c	opy of the clain		ls with your applio				
	лу	Requested Enrollment Ef	fective Date								
	Taxonomy	Printed Name of Person									
	axc	Requesting the Effective Date				Date					
	<b>—</b>		Here to find more i	nformation o	n Effective Dat	tes and Retro Effect	tive Date Policies	5			
		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?	
<b><u>Click Here</u></b> for FAQs and More Resources	

## All Fields are Required unless specifically marked as not required

	Application Tracking #				
L L	Provider Name				
: mation					
1: Z	Service Location				
0	Billing Address				
ы С Т С С	Mailing Address				
Sec	Work Phone				
enti					
lde	Contact Person				
	Phone				
	Email				

		1. How are you filing taxes with the IRS?	Filing under SSN	🗌 Filing under EIN (Tax ID)							
on 2:	on 2: tions	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 Provide Type/Specialty/Taxonomy needed to bill the services provided by the business.									
	Sect id Dues	2. How many Managing Employees (authorized If more than 3 Managing Employees, attach a list as part		s) do you have?							

List must contain First Names, Last Names, Dates of Birth, and SSNs

			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										
		Please ensure you use t	<mark>he links provided</mark>	<mark>l to obtain the cu</mark>	rrent version	<mark>is of each form.</mark>		Helpful Links	Submitted				
		1. <u>Coversheet for Fax/E</u>	<u>Coversheet for</u> Fax/Email										
	nts	2. Sole Proprietor Check											
3: .:	ocume	3. <u>W-9 (10-2018)</u>	Printed Name of	Signing Managing	Employee:			<u>W-9 (10-2018)</u>					
ion	$\Box$	<b>4. License</b> (It is the respons a copy of the license to prov	e state by submitting										
Sec	Ired	License	#	Issued:		Expires:							
	edu	5. DEA (Only Required for	Prescribers)										
	2	DEA	#	Issued:		Expires:							
		6. NPI prinout from the	NPPES Website					NPPES Website					
		7. <u>SFN 661 (12-2022)</u>	Printed Name of	Signing Managing	Employee:			<u>SFN 661 (12-2022)</u>					
		7a. Bank Letter/V	oided Check	Must match the	Information	provided on the	SFN 661						

Page	2	of	2
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8. SFN 1168 (6-2020)       Simulified Instructions based on FAQs         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & dated by the individual Provider who is and SSNs       SFN 615 (6-2023)         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & dated by the individual Provider who is any sphing as a Sole Proprieto.       SFN 615 (6-2023)         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & dated by the individual Provider who is any sphing as a Sole Proprieto.       SFN 615 (6-2023)         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & dated by the individual Provider who is any application.       SFN 615 (6-2023)         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & dated by the individual Provider who is any application.       SFN 615 (6-2023)         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & dated by the individual Provider who is any application.       SFN 615 (6-2023)         9. SFN 615 (6-2023)       Page 4 of the SFN 615 form must be signed & date on Taxonomies       SFN 615 (6-2023)         9. SFN 615 (6-2023)       What is a Taxonomy2 Click Here to find out which Provider Type & Specialty is assigned to your Taxonomy https://www.hhs.nd.gov/sites/www/files/documents/DI55520.eggav/mmis-individual-provider-code-taxonomy.pdf         9. Flease coordinate with your billing department and any other applicable area to determine the correct effective date will deny. A retroactive enrollment effective date is limited to no more than ninety (900) days** prior to the			Page
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         SPECIALTY         TAXONOMY         What is a Taxonomy? Click Here to find more information on Taxonomies         Know your Taxonomy? Click Here to find more information on Taxonomy.         https://www.hhs.nd.gov/sites/www/files/documents/DH5%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 invited 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. We are requesting the date of error is above.         Requested Enrollment Effective Date         Printed Name of Person         Requesting the Effective Date         Printed Name of Person         Requesting the         Date         Click Here to find more inf	3: cuments ed	8. <u>SFN 1168 (8-2020)</u>	Instructions based
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for any application.         PROVIDER TYPE         SPECIALTY         TAXONOMY         Mat 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 thts://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 emplication 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 groupster 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 was received.         This application is associated with an emergency service. We are requesting the date of			
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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 was received.         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         Effective Date       Date         Effective Date       Date		PROVIDER TYPE	
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. We are requesting the date of Refer to the **         above.         Requested Enrollment Effective Date         Printed Name of Person Requesting the Effective Date       Date         Effective Date       Date         Click Here to find more information on Effective Dates and Retro Effective Date Policies		SPECIALTY	
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/DH5%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. 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	b		
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Requested Enrollment Effective Date   Printed Name of Person   Requesting the   Effective Date    Click Here to find more information on Effective Dates and Retro Effective Date Policies	Section &	<b>application is approved</b> and any claims submitted with a date of service prior to effective date will deny. A retroactive enrollment effective date is limited to no more days** prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned from the date the complete application packet was received.	the enrollment e than ninety (90) ent. If the date will be 90 days D days prior to the date
Printed Name of Person       Date         Requesting the       Date         Effective Date       Click Here to find more information on Effective Dates and Retro Effective Date Policies	Taxor		Refer to the **
Requesting the Effective Date     Date       Click Here to find more information on Effective Dates and Retro Effective Date Policies		Requested Enrollment Effective Date	
Effective Date Click Here to find more information on Effective Dates and Retro Effective Date Policies			
Click Here to find more information on Effective Dates and Retro Effective Date Policies			
			sion

# 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
		Application Tracking #		
		Provider Name		
	atic			
	Informatio	Service Location		
, u	nfo	Billing Address		
		Mailing Address		
Se	fyir	Work Phone		
	entifying			
	Ide	Contact Person		
		Phone		
		Email		

		1. How are you filing taxes with the IRS?	☐Filing under SSN	☐Filing under EIN (Tax ID)				
n 2:	ons	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.						
	uest	2. How many Managing Employees (authorized to sig	n on behalf of the busine	ess) do you have?				
Se	ð	If more than 3 Managing Employees, attach a list as part of Section List must contain First Names, Last Names, Dates of Birth, and St		).				

		The documents requested below must be returned to the Department in order to process your enrollment						
		Please ensure you use the links provide	<mark>ed to obtain the cur</mark>	rent version	s of each form.		Helpful Links	Submitted
		1. <u>Coversheet for Fax/Email</u>					<u>Coversheet for</u> Fax/Email	
	nts	2. Sole Proprietor Checklist						
3:	cume	3. <u>W-9 (10-2018)</u> Printed Name		<u>W-9 (10-2018)</u>				
Section	Doc	<b>4. License</b> (It is the responsibility of the provid a copy of the license to provider enrollment ea		nsure informa	ion on file with the sta	te by submitting		
ec	,ed	License #	Issued:		Expires:			
<b>S</b> .	In							
	eq	5. NPI prinout from the <u>NPPES Website</u>	2				NPPES Website	
(	Ŷ							
		6. <u>SFN 661 (12-2022)</u> Printed Name	of Signing Managing I	Employee:			<u>SFN 661 (12-2022)</u>	
		6a. Bank Letter/Voided Check	Must match the	Information	provided on the SFN	661		

Page	2	of	2
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its								Page 2		
Section 3: Required Documents Continued	7. <u>SFN 1168 (8-2020)</u>						<u>Simplified</u> Instructions based <u>on FAQs</u>			
Section 3: ired Docun Continued	7a. List of Managin	g Employees attache	ed to Section III	(Page 2) with da	ates of birth and SSN	ls				
S uir C										
Req	8. <u>SFN 615 (6-2023)</u>	Page Ā of the SFN 6 applying as a Sole I		ą signed Ā date	d Āy the Individual Pi	rovider who is	<u>SFN 615 (6-2023)</u>			
	Proof of Insurance is not re remains tea Ārovider's res application.									
	PROVIDER TYPE	. 3Developmen	tal Disabilities							
	SPECIALTY	508-Service Mana	agement							
	TAXONOMY	A taxonomy code	is not required	d for tĀis provi	der tyĀe/specialty (	combination				
Date		Program Design & Monitoring and Skills Training are specialties only available for entities which are enrolled under the Applied Behavior Analysis Application Checklist.								
Section : ent EffectiĂe D	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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 a complete application packet is received. You must include a copy of the claim and medical records with your a This application is associated with an emergency service. We are requesting the date of above.							plication documents.			
	Requested Enrollment E	ffective Date								
	Printed Name of Person Requesting the Effective Date				Date					
		Here to find more	information o	n Effective Dat	tes and Retro Effec	tive Date Policie	25			
	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 <u>Click Here</u> for the Manual for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Have Questions?

## **<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #	
lation	Provider Name	
	Organizational NPI #	
at	_	
ion 1: Inform	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
Sec /ing	Billing Address	
Sect dentifying	Mailing Address	
der	Facility Phone	
_	·	
	Contact Person	
	Phone	
	Email	

	1. Are you Enrolled in Medicare?	O 🗌 YES Medicare Enrolln	nent 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?		□ YES						
	State Abbv:	Please Provide your Other S	tate Medicaid ID:						
	3. Are you an Out of State Provider (Service location border?)	on more than 50 miles from the North	Dakota 🗌 YES 🗌 NO						
	Dakota or will the servic	plementing or shipping to North es be provided on-site? mplementing/Shipping							
	4. Are you enrolling any additional service locations not listed above at this time?								
Section 2: Questions	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.								
Se D	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 whic (Interest may be direct or indirect)	h have 5% or more interest in the enro	Iling group? 🗌 YES 🗌 NO						
	7 How many Managing Employees (outhowized to	cian on hoholf of the husiness) do you	have2						
	7. How many Managing Employees (authorized to If more than 3 Managing Employees, attach a list as part of So	• • •	naver						
	List must contain First Names, Last Names, Dates of Birth, a								
	8. Are you organized as a corporation, a non-profit	corneration or a government agency	organized as a						
	corporation?	corporation, or a government agency	organized as a YES NO						
	8a. If Yes, how many Boa	rd Members do you have?							
	If more than 3 Board Member 1168 (page 2).	s, attach a list as part of Section III of the SFN							

	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. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> <u>Fax/Email</u>						
	2. Group Application Checklist							
	3. List of Service Locations (Required if you answered Yes to question 4 above)							
	4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>						
	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>						
ts	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						
n 3: ocumen	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:							
oci oci	License # Expires.							
Section ired Do	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)							
qui	License # Issued: Expires:							
Re	9. NPI prinout from the <u>NPPES Website</u>	NPPES Website						
	10. SFN 661 (12-2022)       Printed Name of Signing Managing Employee:	<u>SFN 661 (12-2022)</u>						
	10a. Bank Letter/Voided Check Must match the Information provided on the SFN 661							
	11. <u>SFN 509 (5-2021)</u> (Required for Out of State providers = Answered yes to question 3 above) Date of service must match the enrollment effective date below.	<u>SFN 509 (5-2021)</u>						
	11a. Copy of Claim (Required for Out of State providers = Answered yes to question 3 above) Claims submitted are for Enrollment Purposes Only.							
	12. <u>SFN 1168 (8-2020)</u>	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 opprovider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to b							
	PROVIDER TYPE 033-Suppliers							
Jate	SPECIALTY							
ve	ΤΑΧΟΝΟΜΥ							
ecti	What is a Taxonomy? Click Here to find more information on Taxonomies							
ection 4: rollment Effective Date	<u>Already Know your Taxonomy? Click here to find out which Provider Type &amp; Specialty is assigned to physical structures https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-</u>							
Section 4: Taxonomy & Enrollment	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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.							

Page 2 of 3

\*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.

	& ve Date	This application is	associated with an e	emergency servi	ce. We are requ	uesting the date of	Refer to the * above.	
4:	ecti -	Requested Enrollment Ef	fective Date					
Sectior	I axon Enrollment E Cont	Printed Name of Person Requesting the Effective Date				Date		
	En	Click Here to find more information on Effective Dates and Retro Effective Date Policies						
		Revision	8/22/2023					_

Page 3 of 3

# Group Application Checklist Pharmacy (033)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #						
	Provider Name						
Section 1: Identifying Information	Organizational NPI #						
nat							
1: orn	Service Address						
Section 1: ying Inforr		Only 1 service location	n may be enrolled pe	r Medicaid ID.			
ecti ng	Billing Address						
S€ fyii	Mailing Address						
enti	Facility Phone						
Ide							
	Contact Person						
	Phone						
	Email						
	1. Are you Enrolled in Me Please Provide Is your Medicare Re	our Medicare ID:		es No <u> </u>			
	2. Are you Enrolled in M	edicaid in another St	ate?	□ NO	S YES		
	State Abbv		Ple	ase Provide your Other Sta	ate Medicaid ID:		
·· s	3. Are you an Out of Stat South Dakota?)	e Provider (Service lo	ocation outside No	rth Dakota, Minnesota, Mo	ontana, or	□ YES	🗆 NO
Section 2 Question	4. Are you exempt from	EDERAL taxes?		IO If Exempt from FEDERA	<mark>AL</mark> Taxes, submit you	ur <mark>IRS</mark> issued Tax Exei	mpt Letter.
Sec	5. Do you have any Indiv (Interest may be direct o		which have 5% or	more interest in the enrolli	ing group?	□ YES	□ NO
	6. How many Managing If more than 3 Managing Emp List must contain First Names	loyees, attach a list as pa	rt of Section III of the	lf of the business) do you h SFN 1168 (page 2).	nave?		
	7. Are you organized as a corporation?	•		or a government agency o	organized as a	☐ YES	□ NO
		7a. If Yes, how man If more than 3 Board Mo 1168 (page 2).	-	do you have? a part of Section III of the SFN			

nts	The documents requested below must be returned to the Department in order to process your enrollment								
3: umen	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						
on Doc	1. <u>Coversheet for Fax/Email</u>	Coversheet for Fax/Email							
Sect uired I	2. Group Application Checklist								
Req	3. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>							

		4. CP 575/147C (Not req	uired if submitting a FE	DERAL tax exempt let	ter issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>	
		5. IRS Tax Exempt Letter	(Required if you answe If Exempt from FEDERAL Ta cannot be substituted. The	axes, submit your I <mark>RS</mark> issue	ed Tax Exempt Letter. A Sta	te issued letter	IRS Tax Exempt Letter for Government Agencies	
	ed	6. License/Certification (I by submitting a copy of the lice			censure information on file	e with the state		
	tinue	License #	lssue	ed:	Expires:			
	Conti	7. NPI prinout from the N	IPPES Website				NPPES Website	
3:	$\mathbf{}$	8. SFN 661 (12-2022)	Printed Name of Signing	Managing Employee:			SFN 661 (12-2022)	
Section 3	ments	8a. Bank Letter/Voi			provided on the SFN 661	1		
ect	cur	9. SFN 509 (5-2021)	(Required for Out of State p	providers = Answered yes t	o question 3 above)			
Š	Do	5. <u>51N 505 (5-2021)</u>	Date of service must match (Required for Out of State p			-	SFN 509 (5-2021)	
	ired [	9a. Copy of Claim	Claims submitted are for Er	-				
	equire	10. <u>SFN 1168 (8-2020)</u>					Simplified Instructions based on FAQs	
	R	10a. List of Managin	g Employees attached to	Section III (Page 2) with	dates of birth and SSNs		1705	
			embers attached to Section					
		11. <u>SFN 615 (6-2023)</u>	Printed Name of Signing	g Managing Employee:			<u>SFN 615 (6-2023)</u>	
		12. <u>SFN 1169 (3-2018)</u>	Printed Name of Signing	Managing Employee:			<u>SFN 1169 (3-2018)</u>	
		Proof of Insurance is not rea		If proof of insurance is			a last and fragmentities. Other stra	
		provider's responsibility to						
	0	provider's responsibility to	ensure that the necessary					
	ate	provider's responsibility to PROVIDER TYPE	ensure that the necessary					
	e Date	provider's responsibility to PROVIDER TYPE SPECIALTY	ensure that the necessary 033-Suppliers	y insurance is in place, bu		ot required to be		
		provider's responsibility to PROVIDER TYPE SPECIALTY TAXONOMY Already Know your	ensure that the necessary 033-Suppliers	y insurance is in place, by P Click Here to find mo to find out which Provi	ut proof of insurance is n re information on Taxe ider Type & Specialty i	ot required to be onomies s assigned to yo	e submitted for any ap	
	Effective D	provider's responsibility to PROVIDER TYPE SPECIALTY TAXONOMY <u>Already Know your</u> <u>https://www.hhs.i</u> Please coordinate wi	ensure that the necessary 033-Suppliers <u>What is a Taxonomy?</u> Taxonomy? Click here t nd.gov/sites/www/files th your billing depa	y insurance is in place, bu P Click Here to find mo to find out which Provi s/documents/DHS%20 artment and any o	re information on Tax ider Type & Specialty i Legacy/mmis-group-pu	onomies s assigned to yo rovider-code-ta	e submitted for any ap our Taxonomy xonomy.pdf ine the correct	
4:	ent Effective D	provider's responsibility to PROVIDER TYPE SPECIALTY TAXONOMY <u>Already Know your</u> <u>https://www.hhs.i</u> Please coordinate wi enrollment effective <b>application is app</b>	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here t nd.gov/sites/www/files th your billing depart date. The Depart roved and any clain	y insurance is in place, by P Click Here to find mo to find out which Provi S/documents/DHS%20 artment and any o ment will not ma ms submitted with	re information on Taxe ider Type & Specialty i Legacy/mmis-group-pu ther applicable are <b>ake changes to t</b> n a date of service	onomies s assigned to yo rovider-code-ta ea to determ hat date or prior to the	e submitted for any ap our Taxonomy xonomy.pdf ine the correct ce the enrollment	
	ent Effective D	provider's responsibility to PROVIDER TYPE SPECIALTY TAXONOMY <u>Already Know your</u> <u>https://www.hhs.</u> Please coordinate wi enrollment effective <b>application is appl</b> effective date will de	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here to hd.gov/sites/www/files th your billing depart date. The Depart roved and any claim eny. A retroactive e	Click Here to find mo Click Here to find mo to find out which Provi S/documents/DHS%20 Artment and any o ment will not ma ms submitted with nrollment effective	re information on Taxe ider Type & Specialty i Legacy/mmis-group-pu ther applicable are <b>ake changes to t</b> a date of service e date is limited to	onomies s assigned to yo rovider-code-ta ea to determ bat date or prior to the o no more that	our Taxonomy xonomy.pdf ine the correct ce the enrollment an ninety (90)	
	ent Effective D	provider's responsibility to PROVIDER TYPE SPECIALTY TAXONOMY <u>Already Know your</u> <u>https://www.hhs.i</u> Please coordinate wi enrollment effective <b>application is app</b>	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here to nd.gov/sites/www/files th your billing depart date. The Depart roved and any claim eny. A retroactive end ate a complete ap	Click Here to find mo Click Here to find mo to find out which Provi Artment and any o ment will not ma ms submitted with nrollment effective plication packet is	re information on Taxe ider Type & Specialty i Legacy/mmis-group-pu ther applicable are <b>ake changes to t</b> n a date of service e date is limited to received by the D	onomies s assigned to yo rovider-code-ta ea to determ that date or prior to the prior to the pono more tha Department.	<u>our Taxonomy</u> <u>xonomy.pdf</u> ine the correct <b>ice the</b> enrollment an ninety (90) If the date	
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	axonomy & Enrollment Effective D	provider's responsibility to PROVIDER TYPE SPECIALTY TAXONOMY Already Know your https://www.hhs.i Please coordinate wi enrollment effective application is applied days* prior to the da requested is outside from the date the co *If this application is associated complete application packer	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here to nd.gov/sites/www/files th your billing depart date. The Depart roved and any clain eny. A retroactive end ate a complete application the 90 day timefration ated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in A retroactive set is retroactive s	Click Here to find mo Click Here to find mo to find out which Provi S/documents/DHS%20 Artment and any o ment will not ma ms submitted with nrollment effective plication packet is ame, the enrollme packet was received service, the Department include a copy of the clair	re information on Tax ider Type & Specialty i Legacy/mmis-group-pr ther applicable are ake changes to t a date of service e date is limited to preceived by the D nt effective date a yed.	onomies s assigned to yo rovider-code-ta ea to determ that date or prior to the prior to the partment. Separtment. ssigned will ore than 90 days ith your applicat	e submitted for any ap our Taxonomy xonomy.pdf ine the correct an ninety (90) If the date be 90 days prior to the date a ion documents.	
	axonomy & Enrollment Effective D	provider's responsibility to         PROVIDER TYPE         SPECIALTY         TAXONOMY         Already Know your         https://www.hhs.i         Please coordinate wi         enrollment effective         application is applied         effective date will de         days* prior to the da         requested is outside         from the date the cc         *If this application is associ         complete application packed         This application is         Requested Enrollment Effection         Printed Name of Person	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here to nd.gov/sites/www/files th your billing depart date. The Depart roved and any clain eny. A retroactive end ate a complete application the 90 day timefration ated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in A retroactive set is retroactive s	Click Here to find mo Click Here to find mo to find out which Provi s/documents/DHS%20 artment and any o ment will not ma ms submitted with nrollment effective plication packet is ame, the enrollme packet was received service, the Department include a copy of the clair	re information on Taxa ider Type & Specialty i Legacy/mmis-group-pr ther applicable are <b>ake changes to t</b> n a date of service e date is limited to received by the D nt effective date a /ed.	onomies s assigned to yo rovider-code-ta ea to determ that date or prior to the prior to the partment. Separtment. ssigned will ore than 90 days ith your applicat	e submitted for any ap our Taxonomy xonomy.pdf ine the correct an ninety (90) If the date be 90 days prior to the date a ion documents.	
	axonomy & Enrollment Effective D	provider's responsibility to         PROVIDER TYPE         SPECIALTY         TAXONOMY         Already Know your         https://www.hhs.u         Please coordinate wi         enrollment effective         application is applied         effective date will de         days* prior to the da         requested is outside         from the date the co         *If this application is associ         complete application packed         This application is         Requested Enrollment Effection	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here to nd.gov/sites/www/files th your billing depart date. The Depart roved and any clain eny. A retroactive end ate a complete application the 90 day timefration ated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in A retroactive set is retroactive s	Click Here to find mo Click Here to find mo to find out which Provi s/documents/DHS%20 artment and any o ment will not ma ms submitted with nrollment effective plication packet is ame, the enrollme packet was received service, the Department include a copy of the clair	re information on Tax ider Type & Specialty i Legacy/mmis-group-pr ther applicable are ake changes to t a date of service e date is limited to preceived by the D nt effective date a yed.	onomies s assigned to yo rovider-code-ta ea to determ that date or prior to the prior to the partment. Separtment. ssigned will ore than 90 days ith your applicat	e submitted for any ap our Taxonomy xonomy.pdf ine the correct an ninety (90) If the date be 90 days prior to the date a ion documents.	
	axonomy & Enrollment Effective D	provider's responsibility to         PROVIDER TYPE         SPECIALTY         TAXONOMY         Already Know your         https://www.hhs.i         Please coordinate wi         enrollment effective         application is applied         effective date will de         days* prior to the da         requested is outside         from the date the co         *If this application is associate         This application packed         This application is         Requested Enrollment Eff         Printed Name of Person         Requesting the         Effective Date	What is a Taxonomy? What is a Taxonomy? Taxonomy? Click here to nd.gov/sites/www/files th your billing depart date. The Depart roved and any clain eny. A retroactive end ate a complete application the 90 day timefration ated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in associated with an emergency set is received. You must in A retroactive set is retroactive s	Click Here to find mo to find out which Provi s/documents/DHS%20 artment and any o ment will not ma ms submitted with nrollment effective plication packet is ame, the enrollme packet was received service, the Department nclude a copy of the clair gency service. We are re	re information on Taxa ider Type & Specialty i Legacy/mmis-group-pro- ther applicable are <b>ake changes to t</b> n a date of service e date is limited to received by the D nt effective date a /ed. taxa date of a date mo n and medical records w questing the date of	onomies s assigned to yo rovider-code-ta ea to determ that date or prior to the prior to the partment. essigned will ore than 90 days ith your applicat	e submitted for any ap our Taxonomy xonomy.pdf ine the correct ce the enrollment an ninety (90) If the date be 90 days prior to the date a ion documents. efer to the * above.	

Page 2 of 2

# Group Application Checklist Hearing Aid Specialists (033 - 383)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #										
		Provider Name										
	Identifying Information	Organizational NPI #										
;;	Ĩ	Service Address										
	nfo	Billing Address										
Section	പ്പ	Mailing Address										
Se	tifyi	Facility Phone										
	len	Contact Person										
	2	Phone										
		Email										
		1. Are you Enrolled in Me	dicare?		YES			]				
		Please Provide y	our Medicare ID:									
		Is your Medicare Re	cord up to date?				YES					
		2. Are you Enrolled in Me	dicaid in another	State?			NO	VES				
		State Abbv:			Please Pr	ovide yo	our Other Sta	ate Medicaid ID:				
		3. Are you enrolling any a	additional service If yes, please incl Provider Type, N Please note: Service of in the same record as services have been p	ude a list with PI, EIN, and bil addresses located s out of state servi	the address ling address within North D ice locations. O	es of all ). <sup>akota and</sup>	service loca	es (within 50 miles o	lled (mus	order) cannot l	same be enro	NO lled
5:	ns	4. Are you an Out of State	e Provider (Servic	e location more	e than 50 mi	les from	the North D	)akota				
u0	tio	border?)								YES		NO
Section	Questio		f the claim for the nt documents. The									
0,	U	5. Are you exempt from	FEDERAL taxes?	□ YES		If Exem	pt from FEDER/	<mark>AL</mark> Taxes, submit yo	ur <mark>IRS</mark> issue	d Tax Exempt	t Letter.	
		6. Do you have any Indiv (Interest may be direct o		es which have	5% or more	interest	in the enro	lling group?		YES		NO
		7. How many Managing E If more than 3 Managing Emp List must contain First Names	oyees, attach a list as	part of Section III				nave?				
		8. Are you organized as a corporation?	corporation, a no	n-profit corpor	ration, or a g	overnme	ent agency o	organized as a		YES		NO
			8a. If Yes, how ma If more than 3 Board 1168 (page 2).	•	•		l of the SFN					

	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. <u>Coversheet for Fax/Email</u>	<u>Coversheet for</u> <u>Fax/Email</u>							
	2. Group Application Checklist								
	3. List of Service Locations (Required if you answered Yes to question 3 above)								
nued	4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>							
ontir	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>							
ection 3: cuments C	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							
Sec	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)								
о р	License # Issued: Expires:								
uire	8. NPI prinout from the <u>NPPES Website</u>	NPPES Website							
led	9. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	SFN 661 (12-2022)							
Ŕ	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. <u>SFN 1168 (8-2020)</u>	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:	<u>SFN 615 (6-2023)</u>							
	Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be or provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to								
	PROVIDER TYPE 033-Suppliers								
	SPECIALTY 383-Hearing Aid Equipment								
	TAXONOMY         332S0000X								
	What is a Taxonomy? Click Here to find more information on Taxonomies								
ate	<u>Already Know your Taxonomy? Click here to find out which Provider Type &amp; Specialty is assigned to y</u> <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/mmis-group-provider-code-tax</u>								
Section 4: ment Effective Da	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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.								
Enroll	*If this application is associated with an emergency service, the Department may consider a date more than 90 days complete application packet is received. You must include a copy of the claim and medical records with your application. This application is associated with an emergency service. We are requesting the date of	tion documents.							
	Requested Enrollment Effective Date								
	Printed Name of Person Requesting the Date								
	Effective Date Click Here to find more information on Effective Dates and Retro Effective Date Policies	5							
	Revision 8/22/2023	-	1						

# **Group Application Checklist**

Ambulance (034)

Have Questions? <u>Click Here</u> for FAQs and More Resources

<b></b>										
	Application Tracking #									
	Provider Name									
ion	Organizational NPI #									
lati	·									
1: rr	Service Address									
on Infc	Billing Address									
Section 1: Identifying Information	Mailing Address									
S. ifyi	Facility Phone									
int										
Ide	Contact Person									
	Phone									
	Email									
							_			
	1. Are you Enrolled in Me			VES	Medicare Enrollm	nent is required				
		your Medicare ID:								
	Is your Medicare Re	cord up to date?			□ YES					
	2. Are you Enrolled in M	edicaid in another	State?			☐ YES				
	State Abbv:									
				Please P	rovide your Other St	ate Medicaid ID:				
				Please P	rovide your Other St	ate Medicaid ID:				
	3. Are you enrolling any a		locations not		•	ate Medicaid ID:		YES		NO
	3. Are you enrolling any	additional service l		t listed above	•				L the same	
	3. Are you enrolling any a	additional service l If yes, please inclu Provider Type, NF	ude a list wit PI, EIN, and b	t listed above th the address billing address	at this time? ses of all service loca ).	tions being enrol	□ led (mu	st have		!
	3. Are you enrolling any a	additional service l If yes, please inclu Provider Type, NF Please note: Service a	ude a list wit PI, EIN, and b addresses locate	t listed above th the address pilling address ed within North	at this time? ses of all service loca ). Dakota and bordering cit.	tions being enrol ies (within 50 miles c	led (mu	st have	annot be en	rolled
	3. Are you enrolling any a	additional service l If yes, please inclu Provider Type, NF Please note: Service a	ude a list wit PI, EIN, and b addresses locate s out of state se	t listed above th the address pilling address ed within North I ervice locations.	at this time? ses of all service loca ).	tions being enrol ies (within 50 miles c	led (mu	st have	annot be en	rolled
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2 n	4. Are you an Out of Stat	additional service l If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been pl	ude a list wit PI, EIN, and b addresses locate s out of state se rovided at each	t listed above th the address pilling address ed within North I ervice locations. ( h location.	at this time? ses of all service loca ). Dakota and bordering cit. Dut of state service locati	tions being enrol ies (within 50 miles c ions will only be enro	led (mu	st have	annot be en	rolled
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	4. Are you an Out of Stat border?) If yes, a copy o	additional service I If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been po te Provider (Service of the claim for the nt documents. The	ude a list wit PI, EIN, and b addresses locate out of state se rovided at each e location mo service that	t listed above th the address oilling address ed within North I crvice locations. ( h location. ore than 50 m was provided	at this time? ses of all service loca ). Dakota and bordering cit. Dut of state service locati iles from the North I	tions being enrol ies (within 50 miles c ions will only be enro Dakota edicaid Recipien ir requested effe	led (mu of the ND & Iled in an	st have border) co out of sto YES be subm te for en	innot be en ate record ij itted with prollment	NO
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2 n	<ul> <li>4. Are you an Out of Stat border?) <ul> <li>If yes, a copy of your enrollment</li> </ul> </li> <li>5. Are you exempt from</li> <li>6. Do you have any Indivious of the second s</li></ul>	additional service l If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been pl re Provider (Service of the claim for the nt documents. The FEDERAL taxes? iduals or Businesse	ude a list wit PI, EIN, and b addresses locate sout of state se rovided at each e location mo service that date of serv	t listed above th the address oilling address ed within North ervice locations. O h location. ore than 50 m was provided vice on the cla	at this time? ses of all service loca ). Dakota and bordering cit. Dut of state service locati iles from the North I it to an eligible ND M im must support you	tions being enrol ies (within 50 miles c ions will only be enro Dakota edicaid Recipien ir requested effe RAL Taxes, submit yo	led (mu of the ND & Iled in an	st have border) co out of sto YES be subm te for en ued Tax B	innot be en ate record ij itted with prollment	n NO n er.
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2 n	<ul> <li>4. Are you an Out of Stat border?) If yes, a copy o your enrollmer</li> <li>5. Are you exempt from</li> <li>6. Do you have any Indiv (Interest may be direct o</li> <li>7. How many Managing I If more than 3 Managing Emp List must contain First Names</li> <li>8. Are you organized as a</li> </ul>	additional service I If yes, please inclu Provider Type, NF Please note: Service a in the same record as services have been provider (Service of the claim for the nt documents. The FEDERAL taxes? FEDERAL taxes? iduals or Businesses or indirect) Employees (author loyees, attach a list as s, Last Names, Dates of corporation, a nor 8a. If Yes, how ma	ude a list wit PI, EIN, and b addresses locate is out of state se rovided at each e location mo service that date of serv U YES es which hav rized to sign of part of Section f Birth, and SSM n-profit corp	t listed above th the address oilling address ed within North ervice locations. On h location. The than 50 m was provided vice on the cla NO re 5% or more on behalf of t n III of the SFN 12 Ns poration, or a p	at this time? ses of all service loca ). Dakota and bordering cit. Dut of state service locati iles from the North I it to an eligible ND M im must support you If Exempt from FEDE interest in the enrol he business) do you 168 (page 2).	tions being enrol ies (within 50 miles o ions will only be enro Dakota edicaid Recipien ir requested effe RAL Taxes, submit yo lling group? have?	lled (mu of the ND & Illed in an	st have border) co out of sto YES be subm te for en ued Tax F YES	innot be en ate record ij itted with prollment	nolled NO n er. NO

		d below must be returned to the Department i	norder to process	your enrollment	•	
	Please ensure you use th		Helpful Links	Submitted		
	Outdated versions of for 1. <u>Coversheet for Fax/Er</u>	ms will not be accepted. nail			Coversheet for Fax/Email	
	2. Group Application Ch					
	3. List of Service Locatio	ns (Required if you answered Yes to question 3	above)			
	4. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing Employee:			<u>W-9 (10-2018)</u>	
v t	5. CP 575/147C (Not req	uired if submitting a FEDERAL tax exempt letter	r issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>	
ocuments	6. IRS Tax Exempt Letter	(Required if you answered Yes to question 5 ab If Exempt from FEDERAL Taxes, submit your IRS issued T cannot be substituted. The letter must be issued by the	ax Exempt Letter. A Sta	te issued letter	IRS Tax Exempt Letter for Government Agencies	
ectio	7. Ambulance License (It by submitting a copy of the license)	s the responsibility of the provider to keep updated licensu ense to provider enrollment each time it is renewed)		vith the state		
auir			Expires:	I		
Re		IPPES Website			NPPES Website	
	9. <u>SFN 661 (12-2022)</u> 9a. Bank Letter/Vo	Printed Name of Signing Managing Employee: ided Check Must match the Information p	rovided on the SFN 6	61	<u>SFN 661 (12-2022)</u>	
	10. Claim (Required if yo	u answered Yes to question 4 above) <mark>Claims subn</mark>	nitted are for Enrollme	nt Purposes Only		
	11. <u>SFN 1168 (8-2020)</u>		Simplified Instructions based on FAQs			
	11a. List of Managir	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.					
					<u>SFN 615 (6-2023)</u>	
	12. <u>SFN 615 (6-2023)</u>	Printed Name of Signing Managing Employee:				
	Proof of Insurance is not re	Printed Name of Signing Managing Employee: quired for any application. If proof of insurance is sub ensure that the necessary insurance is in place, but p				
tive Date	Proof of Insurance is not re	ouired for any application. If proof of insurance is sub ensure that the necessary insurance is in place, but p 034-Transportation Services 511-Ambulance-Land 510-Ambulan				
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Effective	Proof of Insurance is not reprovider's responsibility to PROVIDER TYPE SPECIALTY/Taxonomy (Please Choose One) Please coordinate we enrollment effective application is apple effective date will de days*** prior to the requested is outside from the date the constant of the date the constant of the date application is associated application is associated application	quired for any application. If proof of insurance is subtransportation Services         034-Transportation Services         511-Ambulance-Land         Transport 3416L0300X         510-Ambulan         3416         th your billing department and any oth         date.         The Department will not make         roved         and any claims submitted with a         eny. A retroactive enrollment effective         date a complete application packet i         the 90 day timeframe, the enrollment         omplete application packet was received         ated with an emergency service, the Department met is received. You must include a copy of the claim a	proof of insurance is in ce-Air Transport 5A0800X her applicable an <b>ce changes to</b> a date of service date is limited to s received by the t effective date a ed.	ea to determ that date of prior to the o no more th e Departmen assigned will ore than 90 days vith your applicat	ine the correct ine the correct ine the enrollment an ninety (90) int. If the date be 90 days prior to the date a tion documents.	
section 4: onomy & Enrollment Effective	Proof of Insurance is not reprovider's responsibility to PROVIDER TYPE SPECIALTY/Taxonomy (Please Choose One) Please coordinate we enrollment effective application is apple effective date will de days*** prior to the requested is outside from the date the constant of the date the constant of the date application is associated application is associated application	avired for any application. If proof of insurance is sub ensure that the necessary insurance is in place, but 034-Transportation Services 511-Ambulance-Land Transport 3416L0300X 510-Ambulan 3416 th your billing department and any oth date. <b>The Department will not mak</b> roved and any claims submitted with a env. A retroactive enrollment effective e date a <b>complete</b> application packet i the 90 day timeframe, the enrollment omplete application packet was received fated with an emergency service, the Department me et is received. You must include a copy of the claim a associated with an emergency service. We are required	proof of insurance is in ce-Air Transport 5A0800X her applicable an <b>ce changes to</b> a date of service date is limited to s received by the t effective date a ed.	ea to determ that date of prior to the o no more th e Departmen assigned will ore than 90 days vith your applicat	ine the correct ine the correct ine the enrollment an ninety (90) int. If the date be 90 days prior to the date a tion documents.	
section 4: onomy & Enrollment Effective	Proof of Insurance is not reprovider's responsibility to PROVIDER TYPE SPECIALTY/Taxonomy (Please Choose One) Please coordinate w enrollment effective application is app effective date will de days*** prior to the requested is outside from the date the co *If this application is assoc complete application pack This application is	avired for any application. If proof of insurance is sub ensure that the necessary insurance is in place, but 034-Transportation Services 511-Ambulance-Land Transport 3416L0300X 510-Ambulan 3416 th your billing department and any oth date. <b>The Department will not mak</b> roved and any claims submitted with a env. A retroactive enrollment effective e date a <b>complete</b> application packet i the 90 day timeframe, the enrollment omplete application packet was received fated with an emergency service, the Department me et is received. You must include a copy of the claim a associated with an emergency service. We are required	proof of insurance is in ce-Air Transport 5A0800X her applicable an <b>ce changes to</b> a date of service date is limited to s received by the t effective date a ed.	ea to determ that date of prior to the o no more th e Departmen assigned will ore than 90 days vith your applicat	ine the correct ine the correct ine the enrollment an ninety (90) int. If the date be 90 days prior to the date a tion documents.	

# Group Application Checklist Autism Waiver (039)

Have Questions?
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**<u>Click Here</u>** for FAQs and More Resources

	Application Tracking #	]		
	Provider Name			
lation	Service Address			
1: Jrm	Billing Address			
	Mailing Address			
	Facility Phone			
∑.				
Sect Identifying	Contact Person			
der	Phone			
_	Email			

	1. Are you enrolling any additional service locations not listed above at this time? If yes, please include a list with the addresses of all service locations being enroll Provider Type, NPI, EIN, and billing address). Please note: Service addresses located within North Dakota and bordering cities (within 50 miles of in the same record as out of state service locations. Out of state service locations will only be enrol	the ND be	order) canno	ot be enrolled
	services have been provided at each location.		···· <b>,</b> ·····	
on 2: tions	2. Are you exempt from FEDERAL taxes?  YES If Exempt from FEDERAL Taxes, submit you FEDERAL Taxes, submit you	ur <mark>IRS</mark> issu	ed Tax Exen	npt Letter.
Sectior Questic	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
0,0	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	
	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).			

	The documents requested below must be returned to the Department in order to process your enrollment	t	
	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. <u>Coversheet for Fax/Email</u>	Coversheet for Fax/Email	
nents	2. Group Application Checklist		
n 3: ocun	3. List of Service Locations (Required if you answered Yes to question 1 above)		
Section ired Doo	4. <u>W-9 (10-2018)</u> Printed Name of Signing Managing Employee:	<u>W-9 (10-2018)</u>	
Se Require	5. CP 575/147C (Not required if submitting a FEDERAL tax exempt letter issued by the IRS)	<u>What is the</u> <u>CP575/147C?</u>	
	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. SFN 661 (12-2022) Printed Name of Signing Managing Employee:	SFN 661 (12-2022)	
S	7a. Bank Letter/Voided Check Must match the Information provided on the SFN 661		
ient			
n 3: cum ued	8. <u>SFN 1168 (8-2020)</u>	Simplified Instructions based on	
Section 3: red Docur Continued		<u>FAQs</u>	
Sec ired Con	8a. List of Managing Employees attached to Section III (Page 2) with dates of birth and SSNs		
Section 3: Required Documents Continued	8b. List of Board Members attached to Section III (Page 2) with dates of birth and SSNs.		
~		· · · · · · · · · · · · · · · · · · ·	
	9. <u>SFN 615 (6-2023)</u> Printed Name of Signing Managing Employee:	<u>SFN 615 (6-2023)</u>	
	Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to		
	PROVIDER TYPE 039-Developmental Disabilities		
	SPECIALTY		
te	ΤΑΧΟΝΟΜΥ		
ctive Da	Specialties Respite, Self-Directed Supports, Assistive Technology, & Service Management only. Specialties Program Design & Monitoring and Skills Training would be enrolled under the <u>Applied Behavic</u> <u>checklist</u> .	or Analysis (ABA)	
S C	Please coordinate with your billing department and any other applicable area to deter enrollment effective date. <b>The Department will not make changes to that date o</b> <b>application is approved</b> and any claims submitted with a date of service prior to the effective date will deny. A retroactive enrollment effective date is limited to no more t days* prior to the date a <b>complete</b> application packet is received by the Department requested is outside the 90 day timeframe, the enrollment effective date assigned will the date the complete application packet was received.	nce the e enrollment han ninety (90) . If the date	
Specialty & E	*If this application is associated with an emergency service, the Department may consider a date more than 90 day complete application packet is received. You must include a copy of the claim and medical records with your application. This application is associated with an emergency service. We are requesting the date of	ation documents.	
S	Requested Enrollment Effective Date		
	Printed Name of Person		
	Requesting the Date Effective Date		
	Click Here to find more information on Effective Dates and Retro Effective Date Policie	<u>es</u>	
	Revision 8/22/2023		

Page 2 of 2

# Group Application Checklist

Basic Care (043)

Have Questions? Click Here for FAQs and More Resources

	Application Tracking #							
	Provider Name							
ion	Organizational NPI #							
at	_							_
1: orm	Service Address							
on nfc		Only 1 service locat	ion may be enrol	led per Medica	d ID.			
Section 1: ying Inforr	Billing Address							
Se fyir	Mailing Address							
Section 1: Identifying Information	Facility Phone							
qe								
_	Contact Person							
	Phone							
	Email							
	1. Are you Enrolled in Me	dicaid in another	State?			VES		
	State Abbv:			Please Prov	ide your Other St	ate Medicaid ID:		
				_				
2: ns	2. Are you exempt from	FEDERAL taxes?	□ YES		f Exempt from FEDE	RAL Taxes, submit your	IRS issued Tax Exer	npt Letter.
Section Questio	3. Do you have any Indivi (Interest may be direct o		es which have 5	% or more int	erest in the enrol	lling group?	□ YES	□ NO
Se	4. How many Managing F		ized to sign on	behalf of the	husiness) do vou	have?		

ňơ	If more than 3 Managing Emp List must contain First Names	Employees (authorized to sign on behalf of the business) do you h oyees, attach a list as part of Section III of the SFN 1168 (page 2). Last Names, Dates of Birth, and SSNs corporation, a non-profit corporation, or a government agency o		
	corporation?		⊔ YES	
		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		

S	The documents reque	t			
nents	Please ensure you use Outdated versions of		Helpful Links	Submitted	
3: cum	1. <u>Coversheet for Fax/Email</u>				
<u> </u>					
Sect ired	2. Group Application (	Checklist			
nb	3. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing Employee:		<u>W-9 (10-2018)</u>	
Re	4. CP 575/147C (Not r	equired if submitting a FEDERAL tax exempt letter issued by the IRS)			

	5. IRS Tax Exempt Lette	· · ·	ERAL Taxes, subm	it your <mark>IRS</mark> issued	Tax Exempt Letter. A S	State issued letter	IRS Tax Exempt Letter for Government Agencies					
Continued	6. Basic Care License. License for the provider to provider enrollment each	to keep updated licens		•		•						
ont	License	#	Issued:		Expires:							
$\sim$	7. CLIA											
ents	License	#	Issued:		Expires:							
- 3 2	8. NPI prinout from the <u>NPPES Website</u>						NPPES Website					
- סכר	8. NPT prinout from the	INPPLS WEDSILE					INFFES WEDSILE					
	9. <u>SFN 661 (12-2022)</u>	Printed Name of S	<mark>igning Managin</mark> g	g Employee:			<u>SFN 661 (12-2022)</u>					
rec	9a. Bank Letter/Vo	oided Check	Must match th	ne Information	provided on the SFN (	661						
Required	10. <u>SFN 1168 (8-2020)</u>						Simplified Instructions based on FAQs					
	10a. List of Managi	ng Employees attach	ned to Section III	l (Page 2) with c	lates of birth and SSN	ls	<u></u>					
	10b. List of Board N	lembers attached to	Section III (Pag	e 2) with dates	of birth and SSNs.							
-												
	11. <u>SFN 615 (6-2023)</u>	Printed Name of S	igning Managin	g Employee:			<u>SFN 615 (6-2023)</u>					
	12. <u>SFN 308 (5-2005)</u>	Printed Name of S	igning Managin	g Employee:			<u>SFN 308 (5-2005)</u>					
	SPECIALTY TAXONOMY		nomy? Click He		e information on Ta			-				
ate					der Type & Specialt Legacy/mmis-group							
ection 4. nt Effective D	Please coordinate with your billing department and any other applicable area to determine the correct enrollment effective date. <b>The Department will not make changes to that date once the</b> <b>application is approved</b> 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 <b>complete</b> 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.											
Enrollme	*If this application is asso complete application pacl			•	-	•	-					
111												
Ē	This application i	s associated with an	emergency serv	vice. We are red	This application is associated with an emergency service. We are requesting the date of Refer to the * above.							
Ē			emergency serv	vice. We are rec	questing the date of _		Refer to the * above.					
ū		ffective Date	emergency serv	vice. We are rec	questing the date of _ Date		Refer to the * above.					

Page 2 of 2

# Group Application Checklist Indian Health Services (047)

Have Questions?

**<u>Click Here</u>** for FAQs and More Resources

		Application Tracking #							
ion		Provider Name							
	ion	Organizational NPI #							
	nat								
 	Information	Service Address							
		Billing Address							
Section	ing	Mailing Address							
S	tify	Facility Phone							
	Identifying	Contact Person							
	lc	Phone							
		Email							
		1. Do you have a 638 Con	tract?	<b>☐</b> Yes	□No				
			1a. If yes, please s	ubmit the por	tion of your c	ontract which indic	ates the services	s you are contract	ed to provide.
		2. Are you Enrolled in Me	edicare?		☐ YES				
		-	your Medicare ID:						
		ls your Medicare Re	cord up to date?			□ YES			
		3. Are you Enrolled in Me	dicaid in another	State?		□ NO	VES		
		State Abbv:			Please Pro	vide your Other Sta	ate Medicaid ID:		
	S	4. Are you enrolling any additional service locations not listed above at this time? 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).							
n 2		5. Are you an Out of State	Provider (Service	location mor	e than 50 mile	s from the North D	akota	□ YES	
Section	luestio	border?) If yes, a copy of	f the claim for the	service that w	as provided t	o an eligible ND Me	dicaid Recipient	_	
Sec	Qu	your enrollmer	t documents. The	date of servic	e on the claim	must support your	requested effec	tive date for enro	llment.
		6. Are you exempt from	FEDERAL taxes?	□ YES		If Exempt from FEDER	AL Taxes, submit yo	ur IRS issued Tax Exer	npt Letter.
		7. Do you have any Indivi (Interest may be direct o		es which have	5% or more ir	iterest in the enroll	ing group?	□ YES	□ NO
		8. How many Managing E If more than 3 Managing Emp List must contain First Names	loyees, attach a list as	part of Section II	I of the SFN 116		nave?		
		9. Are you organized as a corporation?	corporation, a nor	ו-profit corpo	ration, or a go	vernment agency o	organized as a	□ YES	
			9a. If Yes, how ma If more than 3 Board 1168 (page 2).	•	•				
		I have read and acknowle enrollments) are required etc.) and the individual re must be linked ("affiliate are not actively enrolled application is approved.	d. In order to bill o endering provider, d") to the billing p	n a professior /s must be en rovider recore	nal claim form rolled. Also, t d in the syster	, the billing group ( ne rendering provic n. For all rendering	clinic, practice, ler's record providers who	Enter Initia (required for o	

	The documents requested below must be returned to the Department in order to process your enrollment					
	Please ensure you use the Outdated versions of form	e links provided to obtain the current version ms will not be accepted.	is of each form.		Helpful Links	Submitted
	1. Coversheet for Fax/Em	ail			Coversheet for Fax/Email	
	2. Group Application Che	cklist				
	3. List of Service Location	ns (Required if you answered Yes to question	4 above)			
	4. <u>W-9 (10-2018)</u>	Printed Name of Signing Managing Employee:			<u>W-9 (10-2018)</u>	
ents	5. CP 575/147C (Not requ	ired if submitting a FEDERAL tax exempt lett	er issued by the IRS)		<u>What is the</u> <u>CP575/147C?</u>	
ion 3: Docum		<b>Required if you answered Yes to question 6</b> If Exempt from FEDERAL Taxes, submit your IRS issued cannot be substituted. The letter must be issued by th	Tax Exempt Letter. A Sta	ate issued letter	IRS Tax Exempt Letter for Government Agencies	
Sect uired	7. NPI prinout from the <u>N</u>	PPES Website			NPPES Website	
ed	8. <u>SFN 661 (12-2022)</u>	Printed Name of Signing Managing Employee:			SFN 661 (12-2022)	
~	8a. Bank Letter/Void		provided on the SFN 6	61		
	9. Claim (Required if you	answered Yes to question 5 above) Claims sub	nitted are for Enrollmen	t Purposes Only		
		• •				
	10. <u>SFN 1168 (8-2020)</u>				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. <u>SFN 615 (6-2023)</u>	Printed Name of Signing Managing Employee:			<u>SFN 615 (6-2023)</u>	
	Proof of Insurance is not req	Printed Name of Signing Managing Employee: Juired for any application. If proof of insurance is sensure that the necessary insurance is in place, bu			leleted from the file. It	
	Proof of Insurance is not req provider's responsibility to e	uired for any application. If proof of insurance is s			leleted from the file. It	
ate	Proof of Insurance is not req provider's responsibility to e	uired for any application. If proof of insurance is sensure that the necessary insurance is in place, bu			leleted from the file. It	
	Proof of Insurance is not req provider's responsibility to e	uired for any application. If proof of insurance is s ensure that the necessary insurance is in place, bu 047-Indian Health Services	it proof of insurance is	not required to b	leleted from the file. It	
	Proof of Insurance is not req provider's responsibility to e PROVIDER TYPE SPECIALTY TAXONOMY	uired for any application. If proof of insurance is sensure that the necessary insurance is in place, bu 047-Indian Health Services <u>What is a Taxonomy? Click Here to find mo</u>	it proof of insurance is re information on Ta	not required to b	leleted from the file. It e submitted for any ap	
	Proof of Insurance is not req provider's responsibility to e PROVIDER TYPE SPECIALTY TAXONOMY Already Know your	uired for any application. If proof of insurance is s ensure that the necessary insurance is in place, bu 047-Indian Health Services	it proof of insurance is re information on Ta ider Type & Specialty	not required to b xonomies y is assigned to y	leleted from the file. It e submitted for any ap	
Section 4: Enrollment Effective D	Proof of Insurance is not req provider's responsibility to e PROVIDER TYPE SPECIALTY TAXONOMY Already Know your https://www.hhs. Please coordinate wit enrollment effective application is appr effective date will de days* prior to the da requested is outside	uired for any application. If proof of insurance is sensure that the necessary insurance is in place, bu 047-Indian Health Services <u>What is a Taxonomy? Click Here to find mo</u> Taxonomy? Click here to find out which Prov	re information on Ta ider Type & Specialty Degacy/mmis-group ther applicable and a date of service a date is limited to received by the nt effective date	not required to b <u>xonomies</u> y is assigned to y <u>-provider-code-t</u> rea to determ <b>that date o</b> e prior to the co no more th Department.	leleted from the file. It e submitted for any ap your Taxonomy caxonomy.pdf nine the correct nce the enrollment an ninety (90) If the date	
section 4: nrollment Effective D	Proof of Insurance is not req provider's responsibility to e PROVIDER TYPE SPECIALTY TAXONOMY Already Know your https://www.hhs. Please coordinate wit enrollment effective application is appr effective date will de days* prior to the da requested is outside from the date the co	What is a Taxonomy? Click Here to find mo Taxonomy? Click here to find out which Prov nd.gov/sites/www/files/documents/DHS%20 th your billing department and any o date. The Department will not ma oved and any claims submitted with ny. A retroactive enrollment effective ate a complete application packet is the 90 day timeframe, the enrollme	re information on Ta ider Type & Specialty Degacy/mmis-group ther applicable and a date of service a date of service date is limited to received by the nt effective date red. may consider a date no n and medical records	not required to b <u>xonomies</u> <u>y is assigned to y</u> <u>-provider-code-1</u> rea to determ <u>that date or</u> e prior to the co no more th Department. assigned will nore than 90 days with your applica	leleted from the file. It e submitted for any ap your Taxonomy caxonomy.pdf nine the correct nce the enrollment an ninety (90) If the date be 90 days	
Section 4: & Enrollment Effective D	Proof of Insurance is not req provider's responsibility to e PROVIDER TYPE SPECIALTY TAXONOMY Already Know your https://www.hhs. Please coordinate wit enrollment effective application is appr effective date will de days* prior to the da requested is outside from the date the co *If this application is associa complete application packet	what is a Taxonomy? Click Here to find mo Taxonomy? Click here to find out which Prov nd.gov/sites/www/files/documents/DHS%20 th your billing department and any o date. The Department will not ma oved and any claims submitted with ny. A retroactive enrollment effective ate a complete application packet is the 90 day timeframe, the enrollme mplete application packet was receive ated with an emergency service, the Department et is received. You must include a copy of the clair	re information on Ta ider Type & Specialty Degacy/mmis-group ther applicable and a date of service a date of service date is limited to received by the nt effective date red. may consider a date no n and medical records	not required to b <u>xonomies</u> <u>y is assigned to y</u> <u>-provider-code-1</u> rea to determ <u>that date or</u> e prior to the co no more th Department. assigned will nore than 90 days with your applica	leleted from the file. It e submitted for any ap vour Taxonomy caxonomy.pdf nine the correct nce the enrollment an ninety (90) If the date be 90 days prior to the date a tion documents.	
Section 4: & Enrollment Effective D	Proof of Insurance is not reqprovider's responsibility to e         PROVIDER TYPE         SPECIALTY         TAXONOMY         Already Know your         https://www.hhs.         Please coordinate will         enrollment effective         application is appr         effective date will de         days* prior to the da         requested is outside         from the date the co         *If this application is associa         complete application packed         This application is a         Requested Enrollment         Effective date         Printed Name of         Person Requesting the	what is a Taxonomy? Click Here to find mo Taxonomy? Click here to find out which Prov nd.gov/sites/www/files/documents/DHS%20 th your billing department and any o date. The Department will not ma oved and any claims submitted with ny. A retroactive enrollment effective ate a complete application packet is the 90 day timeframe, the enrollme mplete application packet was receive ated with an emergency service, the Department et is received. You must include a copy of the clair	re information on Ta ider Type & Specialty Degacy/mmis-group ther applicable and a date of service a date of service date is limited to received by the nt effective date red. may consider a date no n and medical records	not required to b <u>xonomies</u> <u>y is assigned to y</u> <u>-provider-code-1</u> rea to determ <u>that date or</u> e prior to the co no more th Department. assigned will nore than 90 days with your applica	leleted from the file. It e submitted for any ap vour Taxonomy caxonomy.pdf nine the correct nce the enrollment an ninety (90) If the date be 90 days prior to the date a tion documents.	
Section 4: & Enrollment Effective D	Proof of Insurance is not req provider's responsibility to e PROVIDER TYPE SPECIALTY TAXONOMY Already Know your https://www.hhs. Please coordinate wit enrollment effective <b>application is appr</b> effective date will de days* prior to the da requested is outside from the date the co *If this application is associa complete application packet This application is a Requested Enrollment Effective date Printed Name of Person Requesting the Effective Date	what is a Taxonomy? Click Here to find mo Taxonomy? Click here to find out which Prov nd.gov/sites/www/files/documents/DHS%20 th your billing department and any o date. The Department will not ma oved and any claims submitted with ny. A retroactive enrollment effective ate a complete application packet is the 90 day timeframe, the enrollme mplete application packet was receive ated with an emergency service, the Department et is received. You must include a copy of the clair	re information on Ta ider Type & Specialty Degacy/mmis-group ther applicable and a date of service a date of service date is limited to received by the nt effective date red. may consider a date no n and medical records questing the date of Date	not required to b	leleted from the file. It e submitted for any ap your Taxonomy caxonomy.pdf nine the correct nce the enrollment an ninety (90) If the date be 90 days prior to the date a tion documents. Refer to the * above.	

## **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/Appl	ication 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 <u>Primary Care Case Management Program page</u> for more information on primary care provider services.





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	
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 <u>NDMedicaidEnrollment@noridian.com</u> 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

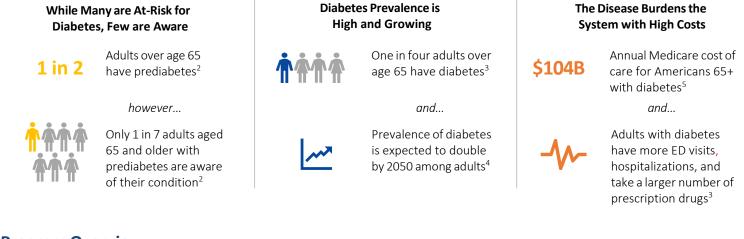
Accessed on 1/17/2022: https://innovation.cms.gov/files/x/mdpp\_overview\_fact\_sheet.pdf

# 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.<sup>1</sup>

### **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.



### **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:



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.<sup>6</sup>
- For more on supplier eligibility visit: <u>https://innovation.cms.gov/Files/x/</u> <u>mdpp-supplierreq-checklist.pdf</u>

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 CDCapproved curriculum.<sup>7,8</sup> 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: <u>https://innovation.cms.gov/Files/f</u> <u>act-sheet/mdpp-beneelig-fs.pdf</u>





Need More Uisit: Information? — http://go.cms.gov/mdpp



Ask a Question: https://cmsorg.force.com/mdpp/

### **The Benefits of MDPP**



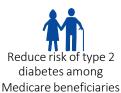
Reach a population that is likely unaware of their prediabetes status



Empower high-risk individuals to take action by improving their health



Create community impact by promoting healthier evidencebased behaviors





Achieve cost-savings through weight loss and improved population health

#### Footnotes

- ${}^{1}https://downloads.cms.gov/files/cmmi/hcia-communityrppm-thirdannualrpt.pdf$
- <sup>2</sup>https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
- <sup>3</sup> <u>http://www.diabetes.org/diabetes-basics/statistics/</u>
- <sup>4</sup> https://www.cdc.gov/media/pressrel/2010/r101022.html

<sup>5</sup>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

<sup>6</sup>https://innovation.cms.gov/Files/x/mdpp-supplierreq-checklist.pdf

<sup>7</sup>https://innovation.cms.gov/Files/fact-sheet/mdpp-coachelig-fs.pdf

<sup>8</sup>https://www.cdc.gov/diabetes/prevention/lifestyle-program/staffing-training.htm



### **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. <u>Click Here</u> 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?

**<u>Click Here</u>** 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?

<u>Click Here</u> 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?

<u>Click Here</u> 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?

<u>Click Here</u> 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?

<u>Click Here</u> 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?

<u>Click Here</u> 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 – <u>NDMedicaidEnrollment@noridian.com</u> (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.

<u>Click Here</u> to find out more about the online Application, including an Online Application Guide and known system issues.

### How to populate the taxonomy in the Online Application.

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

Link to Online Application Guide:

https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollmentapplication-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:

- 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): <u>https://www.hhs.nd.gov/human-services/medicaid/provider/medicaid-providerenrollment-information</u>
- 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. <u>https://npiregistry.cms.hhs.gov/</u>

You have two options to send all documents to the Department:

 Standard Email – <u>NDMedicaidEnrollment@noridian.com</u> (please do not send EFT information, Dates of Birth (DOBs), or Social Security Numbers (SSNs) by unsecured email)
 Fax – Providers may fax the required documentation to (701) 433-5956. ATT: NDM Provider Enrollment

### How to Enroll a Group

- 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: <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS</u> <u>%20Legacy/mmis-group-provider-code-taxonomy.pdf</u>
  - 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.
- Use the following link to pull up the checklist for the Provider Type and Specialty you selected above: <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/group-providerchecklists-pe.pdf</u>
  - 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: <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-instructions-sfn1168.pdf</u>
  - 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

- Review the Online Application Guide to help with navigating, saving, and troubleshooting sections you have questions or trouble with: <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/providerenrollment-application-guide.pdf</u>
- 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: <u>NDMedicaidEnrollment@noridian.com</u> (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.

## 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 10position, 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: <u>https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html</u>

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: <u>https://nppes.cms.hhs.gov/#/</u>

## 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

# **IRS**

# **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

# **Snapshot**

**E-Bulletin** 

# **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 <u>https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html</u> 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 <u>https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/</u> Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

Follow us on Twitter **MedicaidIntegrity** 

## 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=tru e&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=0338d719892f09081c358f 2778322b85&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=048988b 786a7a62635c546cae7c84c18&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=d1711af7388f7b09a5cd9d7b 896846b6&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.** 

### Online Application – 1<sup>st</sup> 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: <u>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/provider-enrollment-application-guide.pdf</u>

Link to Online Application: <u>https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment</u>

### 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-individualprovider-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