

ND Medicaid Provider Enrollment

Individual Provider Enrollment

North Dakota Department of Human Services

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Medicaid Provider Enrollment

Individual Provider Enrollment

Individual Provider Introduction

Procedure

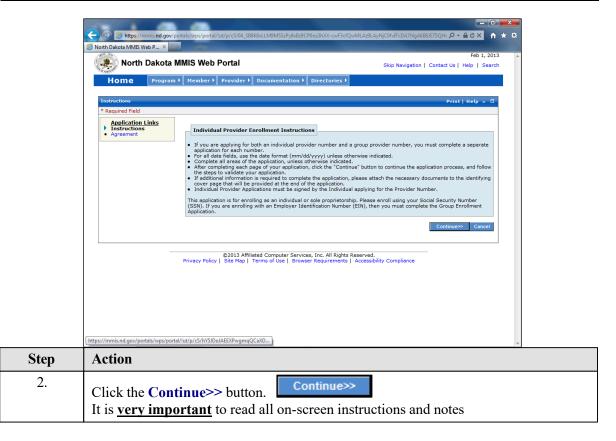
Access ND MMIS Web Portal:

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

North Dakota MMIS Web Portal	Mar 26, 2014 Skip Navigation Contact Us Help Search
Home Program Member Provider Documentation Directories	
Provider Enrollment	Print Help 🗕 🗆
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Become a Provider Enroll to become a Provider by completing the appropriate online entry forms. An individual provider submitting claims to the State of North Dakota will be reported as income under your SSN to the IRS. A group provider submitting claims to the State of North Dakota will be reported as income under the groups' Employer Identification Number (EIN) to the IRS.If you need assistance, please contact Provider Enrollment at (800) 755-2604 during business office hours from Monday to Friday 8 am -5:00pm CST.	Application Status To check the status of your North Dakota Provider or Trading Partner Application, use your Application Tracking # and click the SUBMIT button. *Application Tracking #
FAQ Instructions Group Provider Enrollment Individual Provider Enrollment Download a PDF Provider Enrollment Package Request a Provider Enrollment Package in the Mail	Recall Provider Application To recall an application that you have partially completed, enter your Application Tracking Number, and SSN / EIN and click the SUBMIT button. *Application Tracking #
Become a Trading Partner If you would like to become a Trading Partner (EDI) to exchange business information electronically with North Dakota, you can do so by completing an application on line. If you have any questions regarding the application process, please contact Provider Enrollment at (800) 755-	*SSN/EIN
2604 during business office hours from Monday to Friday, 8am -5pm CST. FAQ Instructions Trading Partner Enrollment	Recall Trading Partner Application To recall an application that you have partially completed, enter your Application Tracking Number and SSN / EIN and click the SUBMIT button. *Application Tracking #
	*SSN/EIN

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Become a Provi					Application Stat				
nroll to become a P rms. An individual ill be reported as ir ubmitting claims to ubmitting claims to nder the groups' Er eed assistance, ple usiness office hour:	provider subm come under y the State of No pployer Identif ase contact Pro	itting claims our SSN to the orth Dakota ication Numb ovider Enrolli	to the State o he IRS. A grou will be reporte ber (EIN) to th ment at (800) am -5:00pm C	f North Dakota ip provider d as income e IRS.If you 755-2604 during	Application, use you Recall Provider To recall an applicat	of your North Dakota Provi r Application Tracking # an *Application Tracking # Application ion that you have partially of Number, and SSN / EIX an *Application	d click the SUBMIT b completed, enter you nd click the SUBMIT b	Submit	
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f you would like to l nformation electron upplication on line. I process, please cont pusiness office hours	cally with Nort you have any act Provider Er	h Dakota, yo questions n proliment at	egarding the a (800) 755-260	y completing an pplication 4 during	To recall an applicat	Partner Application ion that you have partially Number and SSN / EIN and			
			Trading Pa	Instructions irtner Enrollment		*Application	Tracking #		

Step	Action
1.	Click the Individual Provider Enrollment link.
	Individual Provider Enrollment



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Home Progra	m ▶ Member ▶ Provider ▶ Documentation ▶ Directories ▶	
Provider Enrollment Agreem	ent	Print Help = 🗆
* Required Field		
Application Links Instructions	Please ACCEPT or DECLINE this participation agreement.	
Agreement	Provider Acknowledgement	
	 I attest that the following information is true and correct to the be 	est of my knowledge. Providing false information may
	be the basis for the North Dakota Department of Human Services	s refusing or revoking any provider agreements.
		Accept Decline
	©2013 Affiliated Computer Services, Inc. All Rights R Privacy Policy Site Map Terms of Use Browser Requirements	Reserved.
		Accessioney completed
//mmis.nd.gov/nortals/wns/ng	ortal/!ut/p/c5/hY7LCoJQFEW_xS84x7cOr3	

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

Identifying Information

Procedure

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lequired Field	
Application Links Application Tracking Number -	Identifying Information - Section 1 *Last Name *First Name MI Suffix Title
Instructions Identifying Information	Case value Prise value Prise value Prise value V
Licensure / Certification Provider Identifier Numbers	
Service Location Billing Group Affiliation Electronic	*Gender *Can information about date of birth and gender be available to dients? ○ Male ○ Female ○ Yes ◎ No
Transaction Submission Ownership	*SSN
Exclusion / Sanction Qualified Service Providers	Note:Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an
elp	affiliated member, which links you to their EIN.
ame he name associated ith the SSN you enter ust match the legal ame you have given on	Current/Previous ND Provider # Please enter your current and/or previous ND Provider numbers.
	Previous ND Provider IDs
te of Birth	
ur IRS form W9. Ite of Birth 1/DD/YYY or click the ilendar icon to choose date.	ND Provider ID #as
i <u>te of Birth</u> 1/DD/YYYY or click the lendar icon to choose	ND Provider ID #크코

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

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dentifying Information	Print Help = [
* Required Field		
Application Links • Application Tracking Number - • Instructions	Identifying Information - Section 1 "Last Name "First Name MI Suffix Title	
 Identifying Information Licensure / Certification Provider Identifier 	Smith Tim	
Numbers • Service Location Billing • Group Affiliation • Electronic	*Gender *Can information about date of birth and gender be available to dients? Male	
Transaction Submission Ownership Exclusion / Sanction Qualified Service Providers	 SSN 506-55-5555 Note:Your SSN will be linked to your ND Provider number. All daims paid to your ND Provider number will be submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the croup through whom you plan to bill must complete a separate application and list you as an 	
Help	(EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.	
Name The name associated with the SSN you enter must match the legal name you have given on your IRS form W9.	Current/Previous ND Provider # Please enter your current and/or previous ND Provider numbers.	
Date of Birth MM/DD/YYYY or click the Calendar icon to choose a date.	Previous ND Provider IDs Add Previous Provider ID ND Provider ID #===	J
<u>SSN</u> Enter as 9 digits with or without dashes		
Current/Previous ND Provider # : To enter your Current and/or Previous ND	Previous Names Have you used any previous names in the past five years? Ves O No	

Previous ND Provider IDs	Add Previous Provider ID
ND Provider ID #113	
Add Previous ND Provider IDs	Save Reset Cancel
"ND Provider ID #	
	ND Provider 2D 4555 Add Provises ND Provider IDs

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

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Date of Birth	System successfully saved the Information.		
1/DD/YYYY or click the Ilendar icon to choose date.	Previous ND Provider IDs		
<u>SN</u> nter as 9 digits with or	ND Provider ID #크피 000012345		
vithout dashes Current/Previous ND	1 - 1 of 1	1	
Provider # : o enter your Current and/or Previous ND	Previous Names		
Provider #, click the 'Add Previous ND Provider #' outton. Enter the	Have you used any previous names in the past five years?		
equired information and Save the form. Click	⊙ Yes ⊙ No		
anywhere on an existing ow to update or delete he row			
Previous Names:	Continue>> Reset Save Exit Application		
Answer the question. Additional information will			
be required if your response is Yes.			
Click the Save button at the bottom of the page to validate the page			
ontent and save the nformation. Click the			
Continue button to move onto to the next step. If you choose to Exit			
Application, please save and note the Tracking Number or print this page			
o you can make updates to this application at			
another time. If you have any			
questions, please contact Provider Enrollment at			
(800) 755-2604.			

Step	Action
11.	Click the Previous Names Yes or No option.
Step	Action
12.	Click the Save button.

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* Required Field	tails have been saved successfully. Please note your Application Tracking number 124004 for future access to the	÷
Enrollment Application .	tails have been saved successionly. Please note your Application tracking number 124004 for future access to the	L
	Identifying Information- Section 1	
Application Links Application Tracking	Identifying Information- Section 1	-
Number -124004	*Last Name *First Name MI Suffix Title	
 Instructions 		-
✓ Identifying Information		
Licensure /	*Date of Birth	
Certification	12/15/1960	
 Provider Identifier Numbers 	*Gender *Can information about date of birth and gender be available to clients?	
 Service Location 	Male Female Yes No	
Billing Group Affiliation	Wale C Female & Yes C No	
Group Amilation Electronic		
Transaction	*55N	
Submission Ownership	505555555	
Exclusion / Sanction		
 Qualified Service 	Note: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be	
Providers	submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an	
Help	affiliated member, which links you to their EIN.	
•		_
Name The name associated	Current/Previous ND Provider #	
with the SSN you enter		
must match the legal	Please enter your current and/or previous ND Provider numbers.	
name you have given on your IRS form W9.		
	Previous ND Provider IDs Add Previous Provider ID	
Date of Birth MM/DD/YYYY or click the		
	ND Provider ID #2	
Calendar icon to choose		
	000012345	
Calendar icon to choose a date.		
Calendar icon to choose	1 - 1 of 1	

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

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Licensure / 12/15/1960	Π		^
Provider Identifier Numbers *Gender *Can information about date of birth and gender be available to dients?			
Service Location Billing Male ○ Female ● Yes ○ No			
Group Affiliation Electronic Transaction "SSN			
Submission 50555555 Ownership			
Exclusion / Sanction Qualified Service Providers Submitted as income under your SSN to the IRS. If you plan to bill using your Employer Identification Number			n
(EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member, which links you to their EIN.			
Name The name associated			
mite hand associated with the SN you enter must match the legal name vou have given on ? Please enter your current and/or previous ND Provider numbers.			
your IRS form W9. Add Previous Provider ID Add Previous Provider ID			Ξ
Date of Birth MM/DD/YYY or click the Calendar icon to choose ND Provider ID #111			
a date. 000012345			
SSN Enter as 9 digits with or without dashes 1 - 1 of 1			
Current/Previous ND Provider # : Previous Names			
To enter your Current and/or Previous ND Provider #, click the 'Add Have you used any previous names in the past five years?			-
Previous ND Provider #' Yes No button. Enter the			
required information and Save the form. Click anywhere on an existing			
row to update or delete the row Reset Save Exit Application			
Previous Names:			
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Step	Action
14.	Click the Continue >> button.
	Continue>>

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Licensure / Certification	Print Help 🗕 🗖
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Application Links Application Tracking Number 1/24004 ✓ Identifying Information ✓ Certification • Provider Identifier Numbers	Provider Type Provider Type Licensure and Certification - Section 2
Service Location Billing Group Affiliation Electronic Transaction Submission Ownership Exclusion / Sanction Qualified Service Providers	Note: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered. Licensure and Certification List License #^* Lic/Cert Agency** Cert #** State** Effective Date** Expiration Date**
Help Provider Type Select a Provider Type from the available list. Licensure/Certification.	Board Certified Specialty List
Specialty & Taxonomy: To add Licensure/Certification, Specialty and/or Taxonomy information, click the appropriate 'Add'	Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility. Specialty List Add Specialty
button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.	Specialty** Provider Type** Certification #** State** Board Name** Begin Date** End Date**
Taxonomy Enter as 10 digit/alpha characters.	Taxonomy

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

Licensure/Certification

Procedure

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

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Application Trackin Number -124004 Instructions 'Identifying Information Provider Identifier Numbers Service Location Biling Biling Ficular Identifier Transaction Submission Ownership Exclusion (Sanctio Qualified Service Providers Help	
Provider Type Select a Provider Type from the available list Licensure/Certificat Specialty & Taxonom To add Licensure/Certification Specialty and/or Taxonomy information click the appropriate button. Fruter the	Note: Enter information for all the specialties for which you are board certified or eligibile. A specialty requires completion of the appropriate residency program and board certification or eligibility. Specialty List Add Specialty

Step	Action
1.	Click the Provider Type list.
Step	Action
2.	Select the Appropriate provider type.

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Licensure / Certification	Print Help	- 0	
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Application Links • Application Tracking Number - 124004 • Instructions • Identifying Information • Licensure / • Portification • Service Location Billing • Group Affiliation • Electronic Transaction Submission • Ownership • Qualified Service Providers	Provider Type *Provider Type Physicians Iticensure and Certification - Section 2 Note: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered. Licensure and Certification List License #^* Lic/Cert Agency** Cert #** State** Effective Date**		
Help Provider Type from the available list. Licensure/Certification. Specialty & Taxonomy: To add Licensure/Certification. Specialty and/or Taxonomy information. dick the appropriate 'Add' button. Enter the required information and Save the form. at existing row to update or delete the row.	Board Certified Specialty List Note: Enter information for all the specialties for which you are board certified or eligibile. A specialty requires completion of the appropriate residency program and board certification or eligibility. Specialty List Specialty^* Provider Type** Certification #** State** Board Name** Begin Date** End Date		
Taxonomy Enter as 10 digit/alpha	Taxonomy //ut/p/c5/h/SJDolAEEXPwgmqQCaXC		

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

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Application Tracking Number -124004 Instructions Identifying Information Licensure / Certification	*Provider Type Physicians			
 Provider Identifier Numbers Service Location Billing Group Affiliation Electronic Transaction 	Licensure and Certification - Section 2 Note: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered. Add Licensure / Certification			
Submission Ownership Exclusion / Sanction Qualified Service Providers	Licensure and Certification List License #^* Lic/Cert Agency** Cert #^* State** Effective Date** Expiration Date**			
Help	Add Licensure and Certification Save Reset Cancel	el		Ξ
Provider Type Select a Provider Type from the available list. Licensure/Certification, Specialty & Taxonomy: To add Licensure/Certification, Specialty and/or	Add all licenses and certificates. For each instance indicate if you are entering a license or a certification. *Are you adding License or Certification information? © License © Certification			
Taxonomy information, click the appropriate 'Add' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.	Board Certified Specialty List Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility. Add Specialty			
Taxonomy Enter as 10 digit/alpha characters.	Specialty List Specialty* Provider Type* Certification ** State* Board Name* Begin Date* End Date*			
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date. End or	Тахопоту			

Step	Action
5.	Click the License or Certification option.

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*Are you a	nses and certificates. For dding License or Certifical e [©] Certification			itering a lice	nse or a certif	ication.	
*Provider	Туре		*License #	*Licen	sing Agency		
Physician							-
*Effective			*Expiration Date	*State			
				North	Dakota -		
Report Co	ertified Specialty List						
Board Ce	stined Specialty List						1
Note: Ente completion Specialty	r information for all the sp of the appropriate reside List	pecialties for ency program	r which you are board cer n and board certification	rtified or elig or eligibility.		ity requires	
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completion Specialty	of the appropriate reside	ency program	n and board certification	or eligibility.	egin Date ^{▲▼}	Add Specialty	
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completion Specialty	of the appropriate reside List Provider Type~ C	ency program	n and board certification	or eligibility.	egin Date ^{▲▼}	Add Specialty	
completion Specialty Specialty Taxonon	of the appropriate reside List Provider Type~ C	ency program	n and board certification	or eligibility.	egin Date**	Add Specialty	

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

Number -124004 Instructions Instructions (Identifying Information Licensure / Certification Biling Group Affiliation Electronic Transaction Submission Cualified Service Provider Type Physicians Physicians System successfully saved the Information Biling Group Affiliation Electronic Transaction Submission Cualified Service Provider S Licensure and Certification - Section 2 System successfully saved the Information Biling Group Affiliation Electronic Cualified Service Provider S System successfully saved the Information. The licensure and/or certification. The licensure and Certification List Licensure / Certification Dualified Service Provider S elp rovider Type Bed at Provider Type Decisity and/or sonomy information, ck the appropriate fadd we the form. Click mythere on an existing Board Certified Specialty List Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligiblity. Specialty List			
Application Tracking Number 12/004 Instructions Identifying Information Licensure / Certification Group Affliction Billing Group Affliction Electronc Note: Enter information percentations Voties: System successfully saved the information. Note: Enter information percentation go over current licensure and/or certification. Transaction System successfully saved the information. Note: Enter information percentation go over current licensure and/or certification. Transaction System successfully saved the information. The license must be for the state in which services are rendered. Add Licenser (Certification List Cert #A* State** Electronc Provider Type elp consumer / Certification, each of Medical Examiners North Dakota 12/01/2009 12/31/2014 - 1 of 1 Board Certified Specialty List Note: Enter information for all the specialties for which you are board certification or eligiblin. A specialty requires completion of the appropriate residency program and board certification or eligiblin.		ortals/wps/portal/!ut/p/c5/hY5JDoJAEEXPwgmqmNslUzCRRhml2RAiaiAyLAiRPr2tG1c 🔎 🗝 🖒 🗙 👔	🗿 North Dakota MMIS 🛛 🗙
Certification Licensure and Certification - Section 2 Provider Identifier System successfully saved the Information. Billing Group Affiliation Electronic Transaction System successfully saved the Information. Note: Enter information pertaining to your current licensure and/or certification. Transaction System successfully saved the Information. Submission Note: Enter information pertaining to your current licensure and/or certification. Transaction Add Licensure / Certification Carculary / Sanction Add Licensure / Certification Provider Stree Itic/Cert Agency** Cert #** State** Effective Date** Expiration Date** Intersaction Intersaction of Medical Examiners North Dakota 12/01/2009 12/31/2014 Inter information for all the specialties for which you are board certification or eligibility. Add Specialty requires Spacedarty and/or Add Specialty List Add Specialty requires Note: Enter information for all the specialties for which you are board certification or eligibility. Add Specialty Specialty List Add Specialty Specialty List Add Specialty Specialty List Specialty	Application Tracking Number -124004 Instructions Identifying Information	*Provider Type	
Billing System successfully saved the Information. Electronic Transaction Submission System successfully saved the Information. Submission Note: Enter information pertaining to your current licensure and/or certification. Transaction Submission Ownership Exclusion / Sanction Provider Service Fried Cartification List Add Licensure / Certification Add Licensure / Certification Exclusion / Sanction State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 UN45339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Un45339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Un45339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Un45339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Un45339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Un45339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Un45,	Certification Provider Identifier Numbers	Licensure and Certification - Section 2	
Transaction Submission Consisting Submission Consisting Submission Consisting Submission Consisting Submission Consisting Submission Consisting Submission Consisting Provider State Provider Type elect a Provider Type mother available list. Icensure / Certification List Consure / Certification License # * Lic/Cert Agency * Cert # * State * Effective Date* Expiration Date* INM5339990 State Board of Medical Examiners North Dakota 12/01/2009 12/31/2014 Board Certified Specialty List Board Certified Specialty List Note: Enter information Kit he appropriate Yead uttor, Enter the gapropriate residency program and board certification or eligibile. A specialty requires completion of the appropriate residency program and board certification or eligibile. A specialty requires completion of the appropriate residency program and board certification or eligibile. A specialty requires completion of the appropriate residency program and board certification or eligibility. Specialty List	Billing Group Affiliation Electronic	1.1	
Cert #+** Cert #+** Effective Date*** Expiration Date** Interview Itic/Cert Agency** Cert #+** Effective Date*** Expiration Date** Interview Itic/Cert Agency** Cert #+** State** Effective Date*** Expiration Date** Interview Interview Interview North Dakota 12/01/2009 12/31/2014 Interview Interview Interview Interview Interview Interview Interview Interview Interview Interview Interview Interview </td <td>Submission Ownership</td> <td>The license must be for the state in which services are rendered.</td> <td>Add Licensure / Certification</td>	Submission Ownership	The license must be for the state in which services are rendered.	Add Licensure / Certification
I - 1 of 1 I - 1 of 1 Board Certification, pecialty & Taxonomy: a add certified Specialty List Board Certified Specialty List Board Certified Specialty List Board Certified Specialty List System of the appropriate Add spropriate residency program and board certification or eligibility. Add Specialty List Specialty Contification deleted	Qualified Service		ve Date** Expiration Date**
rovider Type elect a Provider Type om the available list. Image: 1 of 1 Board Certification, pecialty & Iaxonomy: add censure/Certification, pecialty add or exonomy information and second yr information add Board Certified Specialty List Board Certified Specialty List Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires uputed information and board certification or eligiblity. specialty List Add Specialty Specialty List Specialty List Specialty Certification, exonomy information and board certification or eligibility. specialty List Specialty Certification, exonomy information and board certification or eligibility. Specialty List Specialty Certification, exonomy information and board certification or eligibility.	lelp	LN45339990 State Board of Medical Examiners North Dakota 12/01/	2009 12/31/2014
	elect a Provider Type rom the available list. iccensure/Certification, pecially & Taxonomu: o add iccensure/Certification, pecialty and/fication, pecialty and/fication, pecialty and/fication, pecialty and/fication, pecialty and/fication, pecialty and/fication, avonomy information dick the appropriate 'Add icc the appropriate 'Add icc the appropriate 'Add avonomy information and is we the form. Click invywhere on an existing ow to update or delete	Note: Enter information for all the specialties for which you are board certified or completion of the appropriate residency program and board certification or eligibil Specialty List	Add Specialty

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

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

Specialty & Taxonomy: To add	Doard Certifica Speciary ED	A.			
Licensure/Certification, Specialty and/or Taxonomy information, click the appropriate 'Add' button. Enter the required information and		ne specialties for which you are boa esidency program and board certific		A specialty requires	
Save the form. Click anywhere on an existing row to update or delete the row.	Specialty** Provider Type*	Certification #** State** B	oard Name** Begin	n Date ∸ ▼ End Date⁴	
Taxonomy Enter as 10 digit/alpha	add Specialty			Save Reset Car	icel
characters.	*Specialty	Provider Type Physicians		¥	
Date Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date. End or	*Begin Date	*End Date		*State North Dakota	-
Expiration Date should be greater than Begin or Effective Date.	*Certification #	*Board Name	-		
Click the Save button at the bottom of the page to validate the page					
content and save the information. Click the Continue button to move onto the next step. If you choose to Exit Application , please	Taxonomy			Add Taxonomy	
save and note the Tracking Number or print	Taxonomy ^{▲▼}	Begin Date**	End Date	**	
this page so you can make updates to this application at another time.					
If you have any questions, please contact Provider Enrollment at (800) 755-2604.			Continue>> Reset	Save Exit Applicatio	

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

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

individual-provider-code-taxonomy.pdf

Specialty & Taxonomy:	- Dourd Certin	eu opeciaity cio						TT
To add Licensure/Certification,	,						,	
Specialty and/or Taxonomy information,	1	sfully saved the i						
click the appropriate 'Add'	Note: Enter info completion of the	ormation for all th	e specialties for w sidency program a	hich you are and board ce	e board certified or eli ertification or eligibility	gible. A specialt	y requires	
button. Enter the required information and	Specialty List					A	dd Specialty	
Save the form. Click anywhere on an existing	specialty List	L						
row to update or delete the row.	Specialty**	Provider Type	Certification #^	State≏▼	Board Name ^{▲▼}	Begin Date≁	End Date [▲] ▼	
Taxonomy	Internal	Physicians	CN88988589	North	AmBd Internal	12/01/2009	12/31/2014	
Enter as 10 digit/alpha characters.	Medicine			Dakota	Medicine			
Date	1 - 1 of 1							
Enter as MM/DD/YYYY,								
MM-DD-YYYY, MMDDYYYY or click the Calendar icon	Taxonomy							
to choose a date. End or Expiration Date should be								+
greater than Begin or Effective Date.							d Taxonomv	
						Aut	а тахопошу	
Click the Save button at the bottom of the page	Taxonomy		Begin Date		End	Date * *		Π
to validate the page content and save the	Тахоношу		begin bute		Lind	bute		
information. Click the Continue button								
to move onto the next								
step. If you choose to Exit Application, please					Continue>> Res	et Save Ex	kit Application	
save and note the Tracking Number or print								
this page so you can make updates to this								
application at another								
time.								
If you have any								
questions, please contact Provider Enrollment at								

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

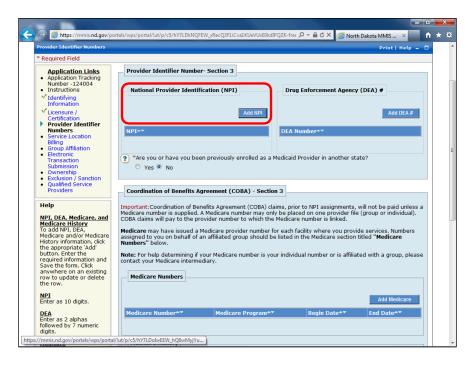
Specially & Laxonomy: To add		· · ·	_					Г
Licensure/Certification, Specialty and/or Taxonomy information, click the appropriate 'Add' button. Enter the required information and	Note: Enter info completion of th Specialty List	e appropriate res	e specialties for w sidency program a	hich you ar and board co	e board certified or eli ertification or eligibility		y requires Id Specialty	
Save the form. Click anywhere on an existing row to update or delete	Specialty▲▼	Provider Type	Certification #^	State▲▼	Board Name▲▼	Begin Date≁	End Date▲▼	
the row.	Internal Medicine	Physicians	CN88988589	North Dakota	AmBd Internal Medicine	12/01/2009	12/31/2014	
Taxonomy Enter as 10 digit/alpha characters.	1 - 1 of 1			Dakota	Medicine			
Date Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date. End or	Taxonomy							
Expiration Date should be greater than Begin or Effective Date.						Add	Taxonomy	
Click the Save button at the bottom of the page to validate the page content and save the	Taxonomy▲▼		Begin Date	A -	End	Date▲▼		
information. Click the Continue button	Add Taxonomy					Save F	Reset Cancel	١
to move onto the next step. If you choose to Exit Application, please save and note the Tracking Number or print this page so you can	*Taxonomy (10) digits/alphas)	*Begin Da	te	End Da	te		J
make updates to this application at another time.					Continue>> Res	set Save Ex	it Application	
If you have any questions, please contact Provider Enrollment at (800) 755-2604.								

Step	Action
23.	Enter the desired information into the Taxonomy (10 digits/alphas) field.
Step	Action
24.	Enter the Begin Date .
Step	Action
25.	Enter the End Date. Enter 12/31/9999.
Step	Action
26.	Click the Save link.
	Save

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Specialty & raxonomy: To add Licensure/Certification, Specialty and/or Taxonomy information, dick the appropriate 'Add' button. Enter the required information and	Note: Enter info completion of th Specialty List	le appropriate res	e specialties for w sidency program a	rhich you are and board ce	e board certified or e ertification or eligibilit		cy requires dd Specialty	
Save the form. Click anywhere on an existing	Specialty▲▼	Provider Type	Certification #*	State≜▼	Board Name**	Begin Date≁	End Date**	
row to update or delete the row.	Internal	Physicians	CN88988589	North	AmBd Internal	12/01/2009	12/31/2014	
Taxonomy Enter as 10 digit/alpha characters.	<u>Medicine</u> 1 - 1 of 1			Dakota	Medicine			
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or	Taxonomy System succes	sfully saved the I	nformation.]
Effective Date.						Add	i Taxonomy	
Click the Save button at the bottom of the page	Taxonomy**		Begin Date	A.T.	Enc	Add	i Taxonomy	
Click the Save button at the bottom of the page to validate the page content and save the	Taxonomy** 1234567890		Begin Date 12/01/2009				i Taxonomy	
Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button to move onto the next						Date≛▼	i Taxonomy	
Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button	<u>1234567890</u>				12/	Date** 31/2014	d Taxonomy	

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

Provider Identifier Numbers Procedure



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

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Provider Identifier Numbers	Print Help 🗕 🗖		
* Required Field			
Application Links Application Tracking	Provider Identifier Number- Section 3		
Application fracking Number -124004 Instructions	National Provider Identification (NPI) Drug Enforcement Agency (DEA) #		
 Identifying Information 			
Licensure / Certification	Add NPI Add DEA #		
Provider Identifier Numbers Service Location	NPIAT DEA NumberAT		
Service Location Billing Group Affiliation			
Electronic Transaction	Add NPI Save Reset Cance		
Submission Ownership	*NPI		
Exclusion / Sanction Qualified Service Providers			
Help	? *Are you or have you been previously enrolled as a Medicaid Provider in another state?		
NPI, DEA, Medicare, and	○ Yes ◉ No		
Medicare History To add NPI, DEA,			
Medicare and/or Medicare	Coordination of Benefits Agreement (COBA) - Section 3		
History information, click the appropriate 'Add' button. Enter the required information and	Important:Coordination of Benefits Agreement (COBA) claims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA claims will pay to the provider number to which the Medicare number is linked.		
Save the form. Click anywhere on an existing row to update or delete the row.	Medicare may have issued a Medicare provider number for each facility where you provide services. Numbers assigned to you on behalf of an affiliated group should be listed in the Medicare section titled "Medicare Numbers" below.		
<u>NPI</u> Enter as 10 digits.	Note: For help determining if your Medicare number is your individual number or is affiliated with a group, please contact your Medicare intermediary.		
DEA Enter as 2 alphas followed by 7 numeric	Medicare Numbers		
digits.	Add Medicare		

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



Step	Action
4.	Click the Add DEA # button. Required for individuals with a DEA.
	Add DEA #

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Provider Identifier Numbers	Print Help 🗕 🗖
* Required Field	
Application Links Application Tracking Number - 124004 Instructions Lidentifying Information Licensure / Certification Provider Identifier	Provider Identification (NPI) National Provider Identification (NPI) Add NPI Add DEA #
Numbers • Service Location Billing	NPI~* DEA Number**
 Group Affiliation Electronic Transaction Submission Ownership 	1 - 1 of 1 Add DEA # Save Reset Cancel *DEA Number
Exclusion / Sanction Qualified Service Providers Help	"Are you or have you been previously enrolled as a Medicaid Provider in another state? Yes No
NPI, DEA, Medicare, and Medicare History To add NPI, DEA, Medicare and/or Medicare	
History information, click the appropriate 'Add' button. Enter the required information and Save the form. Click	Important:Coordination of Benefits Agreement (COBA) daims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA claims will pay to the provider number to which the Medicare number is linked.
anywhere on an existing row to update or delete the row.	Medicare may have issued a Medicare provider number for each facility where you provide services. Numbers assigned to you on behalf of an affiliated group should be listed in the Medicare section titled "Medicare Numbers" below.
<u>NPI</u> Enter as 10 digits.	Note: For help determining if your Medicare number is your individual number or is affiliated with a group, please contact your Medicare intermediary.
DEA Enter as 2 alphas followed by 7 numeric digits.	Medicare Numbers
Medicare	Add Medicare

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

Required Field		Print Help = 🗆	
required ricid			
Application Links • Application Tracking Number -124004 • Instructions V Identifying	Provider Identifier Number- Section 3 National Provider Identification (NPI)	Drug Enforcement Agency (DEA) #	
Information Licensure / Certification Provider Identifier Numbers Service Location	Add NPI	System successfully saved the Information.	
Service Location Billing Group Affiliation Electronic Transaction	<u>1649281361</u> 1 - 1 of 1	DEA Number Total DE1234567	
Submission Ownership Exclusion / Sanction Qualified Service Providers		a Medicaid Provider in another state?	
Help NPI, DEA, Medicare, and	*Other Medicaid State		
Medicare History To add NPI, DEA, Medicare and/or Medicare	Coordination of Benefits Agreement (COBA) - Sect	tion 3	
History information, click the appropriate 'Add'	Important:Coordination of Benefits Agreement (COBA) daims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA daims will pay to the provider number to which the Medicare number is linked.		
button. Enter the required information and Save the form Click	Modicare may have issued a Medicare provider number	r for each facility where you provide services. Numbers	
	assigned to you on behalf of an affiliated group should Numbers" below.	be inter in the medicare becalon data interacting	

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

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NPI, DEA, Medicare, and						
Medicare History	Coordination of Benefits Agreement (COBA) - 5	Jection 3				
To add NPI, DEA,						
Medicare and/or Medicare	Important:Coordination of Benefits Agreement (CO	nportant:Coordination of Benefits Agreement (COBA) claims, prior to NPI assignments, will not be paid unless a				
History information, click the appropriate 'Add'		dicare number is supplied. A Medicare number may only be placed on one provider file (group or individual).				
button. Enter the	COBA claims will pay to the provider number to white	A claims will pay to the provider number to which the Medicare number is linked.				
required information and	Medicare may have issued a Medicare provider nur	nhar far oach facility whore you prov	ido convisos. Numbora			
Save the form. Click	assigned to you on behalf of an affiliated group sho					
anywhere on an existing	Numbers" below.	ald be listed in the medical e section	raded Healcare			
row to update or delete						
the row.	Note: For help determining if your Medicare number	is your individual number or is affilia	ated with a group, please			
	contact your Medicare intermediary.					
<u>NPI</u> Enter as 10 digits.						
Encer as to digits.	Medicare Numbers					
DEA						
Enter as 2 alphas						
followed by 7 numeric			Add Medicare			
digits.			Add Medicare			
Medicare	Medicare Number	am▲▼ Begin Date ▲▼	End Date**			
Select at least one	Medicare Number-* Medicare Progr	am Begin Date	End Date			
Program for each						
Medicare entry.						
	Add Medicare #		Save Reset Cancel			
Medicare History Enter the required						
information for former						
Medicare	*Medicare Number *Begin Date	e *End Date				
Carrier/Intermediaries						
Date Enter as MM/DD/YYYY,	*Please check all that apply:					
MM-DD-YYYY or MMDDYYYY						
or click the Calendar icon	🔲 All 🔲 Medicare Program A 📃 Medicare	e Program B 🛛 🔲 Medicare Program	m C 🔲 Medicare			
to choose a date. End or	Program D					
Expiration Date should be	Program b					
greater than Begin or						
Effective Date.	Medicare History					
Click the Save button at						
	For historical purposes, plaase list any Medicare D	rovidor#(a) and Carrier/Intermedian	w #(c)			
the bottom of the page		r historical purposes, please list any Medicare Provider#(s) and Carrier/Intermediary #(s)				
to validate the page	Tor historical purposes, please list any medicare p					
to validate the page content and save the	For historical purposes, please list any medicale p		Add History			
to validate the page content and save the information. Click the	Tor historical purposes, please list any redicare p		Add History			
to validate the page content and save the information. Click the Continue button to move						
to validate the page content and save the information. Click the	Medicare #** Carrier/Intermediary Name**		Add History Date** End Date**			

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

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	Medicare Numbers	reulary.			
				Add Medicare	
	Medicare Number**	Medicare Program ^{**} A,B,D	Begin Date** 12/01/2012	End Date** 12/31/2014	
	1 - 1 of 1	A,B,D	12/01/2012	12/31/2014	
	Medicare History				
	ar historical purposes pla	ase list any Medicare Provider#(s) a	nd Carrior/Intermediany	#(c)	
	or historical purposes, ple	ase not any medicare Provider#(s) a	na camer/intermediary i	≄(s) Add History	
	Medicare #^▼ Carrier/	Intermediary Name** Medica	re Program^▼ Begin	Date** End Date**	
	Add History			Save Reset Cancel	
	*Medicare #	*Carrier/Intermediary *Begin D Name	ate *End	Date	
		_			
	*Please check all that app			_	
	Medicare Pro	ogram Medicare Program B C	Medicare Program	Medicare Program	/
			-		
		1	Continue>> Reset S	ave Exit Application	
Help]				
NPI, DEA, Medicare, and Medicare History					

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

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

Service Location Billing

Procedure

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Fronders	Service Location Information- Section 4 Physical Address (P.O. Box not accepted) Building, Suite #, etc City *State *Zip County Validate Address Service Location Contact Person	Add Service Location Phone Numbers Phone #~* Fax #~* Add Service Location Contact Person Phone** Ext.** Fax* Cell** Emile*
	Service- Section 4 *Gender Served: Male All Female 0-5 Years Both 13-17 Years 22-59 Years 60+ Years Please define your service area by Counties serve Counties Served Distance From Location	*Languages Supported: Available: Available: Ananian American Sign Language Bangia Other Language: ed, or by distance from your location.

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

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Submission Ownership Exclusion / Sanction Oualified Service	on							
Qualified Service Providers								
	Service Location In	formation- Section 4						
		O. Box not accepted)			Add Service Lo	cation Phone Number	s	
	100 Main Street			Pho	one #^~	Fax #^▼		
	Building, Suite #, etc							
	*City	*State	*Zip					
	Bismarck	North Dakota	58501					
	*County Burleigh -							
	Validate Address							
		Alternate Address	5					
	Cancel' to return to Invalid Service Locati Addresses.	of valid suggestions the make additional chan on Address. Please sei Bismarck,ND,58501,38 ion warning, and acce	i ges. lect one of the 351,Burleigh Co	Alternative				
	Service Location C	contact Person			Add Service Lo	cation Contact Perso	n	
	Last Name**	First Name ^{≁▼}	MI** P	none ** E	xt.** Fax**	Cell-* Ema	il**	

Step	Action
5.	Click the Validate Address button. Validate Address
Step	Action
6.	Click on the Appropriate address.
Step	Action
7.	Click the Submit button. Submit

*Physical Address (100 W Main Ave	P.O. Box not accepted	d)		Add		ation Phone N		Ŋ
Building, Suite #, et	tc							
*City Bismarck	*State North Dakota	*Zip • 58501	3851	Add Service	e Location I		bers Reset Cano	el
*County Burleigh - Validate Address		,		*Phone #		Fax #		
Service Location	Contact Person			Ad	d Service Loo	cation Contac	t Person	
Last Name**	First Name**	MI	Phone**	Ext.**	Fax**	Cell	Email [▲] ▼	
Male	4 *Age Range Served: All 0-5 Years 13-17 Years 22-59 Years	6-12 Years 18-21 Years	Available Albania Americ Arabic Bangla	an an Sign Lang	× .	Selected: English	-	

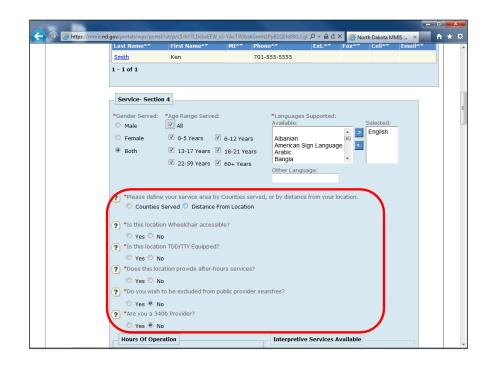
Step	Action
8.	Click the Add Service Location Phone Numbers button.
Step	Action
9.	Enter the desired information into the Phone # field.
Step	Action
10.	Click the Save link.
	Save

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Physical Address (P.O. Box not accepted) Add Service Location Phone Numbers 100 W Main Ave Phone #→ Building, Suite #, etc Fax #→*
*City *State *Zip 1 - 1 of 1 Bismarck North Dakola • 58501 3851 *County Burleigh • Validate Address
Service Location Contact Person Add Service Location Contact Person
Add Service Location Contact Person Save Reset Cance
"Last Name "First Name Middle Initial
*Phone Ext. Fax Cell Phone Ext. Fax Cell Phone Ext.
- Service- Section 4
*Gender Served: *Age Range Served: *Languages Supported: Male All Female O-5 Years 6-12 Years Albanian

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

Last Name** First Name** M1** Phone** Ext.** Fox** Cell** Email** Smith Ken 701-555-5555 Fox** Cell** Email** Smith Ken 701-555-5555 Fox** Cell** Email** Service- Section 4 * * Cell** Fox** Cell** Email** * Gender Served: * * * Languages Supported: Selected: English Male All 0 0-5 Years 6-12 Years Abanian American Sign Language English Both 13-17 Years 18-21 Years 18-21 Years Other Language: Cher Language English * 22-59 Years 60+ Years Other Language: Cher Language:<	nd gov/portals/wns/portal	/ut/p/c5/bV7LDoIwEEW_vS	-VAcTWIba	kGmm1BnB200b8BKI Ca		X CN	eth Dalueta M	□	
* Gender Served: * Age Range Served: * Languages Supported: Selected: Male □ 0-5 Years □ 6-12 Years Albanian American Sign Language Image: Both □ 13-17 Years □ 18-21 Years □ Abanian American Sign Language Image: Image: * Please define your service area by Counties served, or by distance from your location. Other Language: Other Language * * It this location Wheelchair accessible? ○ Yes Image: No * To you wish to be excluded from public provider searches? Yes Image: Yes Image: * To you a 340b Provider? * Are you a 340b Provider?	Last Name** Smith	First Name**		Phone**					
 Yes No Yes No *Is this location TDD/TTY Equipped? Yes No *Does this location provide after-hours services? Yes No *Do you wish to be excluded from public provider searches? Yes No *Are you a 340b Provider? 	*Gender Served: Male Female Both	 *Age Range Served: All 0-5 Years 13-17 Years 22-59 Years your service area by C 	18-21 Yea 60+ Years Counties s	Available: Albanian American Si Arabic Bangla Other Langu: erved, or by distance	gn Languag age:	je 🔽			
⊖ tes ⊛ No	 Yes Yes No) n TDD/TTY Equipped?)))))))))))))))))))	rs service:						

Step	Action
17.	Click the Appropriate Gender option.
Step	Action
18.	Click the Appropriate Age Range and Language options.



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

Hours Of Operation		Interpretive Services Available
1	Add Hours of Operation	Add Interpretive Services Available
Day of Week 🗘	Open 🗘 Close 🇘	Interpretive Services Available 🏮
Special Needs		
🔲 Mental Health Disa	bilities	Deaf/Hearing Impaired Disabilities
Substance Abuse	Disabilities	HIV/AIDS Disabilities
Development Disa	bilities	Physical Handicapped Disabilities
Behaviorally Disrup	otive Disabilities	Sexually Aggressive Disabilities
Other Disabilities		Blind/Visually Impaired Disabilities
Clinical Laborator	y Improvement Amendmen	te (CLIA)
	y Improvement Amendmen	IS (CLIA)
Mailing Address		
s this mailing address Yes O No	the same as service location	1?

A mis.nd.gov/portals/wps/portal/!ut/p/	5/hY5JDoJAEEXPwamaGBuXzRBIoFF	GgO0hwOEiw4IO4fS 🔎 - 🔒 C 🗙	Average Antices And Average Av	★ ☆
○ Yes ● No Hours Of Operation		Interpretive Services Avai		^
Day of Week 🗘	Add Hours of Operation Open Close Close	Add Interpretive	Services Available able 🏮	
Special Needs				E
Mental Health Disal Substance Abuse D		 Deaf/Hearing Impaired Dis HIV/AIDS Disabilities 	abilities	
Development Disab Behaviorally Disrup Other Disabilities		 Physical Handicapped Disa Sexually Aggressive Disabi Blind/Visually Impaired Disa 	ilities	
Clinical Laboratory	' Improvement Amendments (CLIA)		
	he same as service location?			
Yes No Inttps://mmis.nd.gov/portals/wps/portal/Jut/p/c5/hY5/DoJAEEXI	² wgmqGBuXz	Add Mailin	g Location Numbers	

Step	Action
23.	CLIA section does not apply to individual enrollment applications. Skip this section.

¢	🕞 🙆 https://mm	is. nd.gov /portals/wps/portal/!ut/p/c2	/hY5JDoJAEEXPwgmqQCaXbUMwgW	5IFNgQ4hSIDAtCs 🔎 - 🔒 🖒 🗙	Ø North Dakota MMIS	ت – ا ۸	★ \$
		Clinical Laboratory System successfully save	Improvement Amendments (Cl		Add CLIA]	*
		CLIA #^~	Begin Date**	End Dat	e * ▼		
		35D1055181	12/01/2012	12/31/2	012		
		1 - 1 of 1					
		 Yes No Mailing Location Phone 			ng Location Numbers		H
		▲ ▼Phone		Fax #▲▼			
		Service Location Cont		Add Mailing Locati	on Contact Person		
				Phone** Ext.** F	ax** Email**		
		Electronic Funds Trans	fer (EFT) Payments	or Doumonte?			

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

https://mmis.ne	d.gov/portals/wps/portal/!ut/p/c5/hY7LD		GCoPT 🔎 - 🔒 C 🗙 🥔 North Dakota Mi	MIS × 💼 🕇 🛧 🌣
	Electronic Funds Transfer (EF	T) Payments		
	*Do you wish to participate i	n Electronic Funds Transfer Payme	ents?	
	🖲 Yes 🖱 No			
	*Bank Name			
	*Bank Address			
	Address			
	*City	*State *Zip		
				в
	*Bank Routing Transit Number What is this?	*Bank Account Number What is this?	*Account Type	
	*Bank Phone #	*Account Holder Name	*Payee Provider's Name	
		Account Holder Hame		
	Billing Address			
	Note:The billing address is equiv	alent to your Pay To address wher	re vour checks will be mailed	
	*Is this billing address the same	as the service location?	e your checks will be mailed.	
	o res o No			
			Add Billing Location Number	s
	Billing Location Phone Numb			
	^ ▼Phone #	Fax	x #^~	-

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

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

A https://mmis.n	1.gov /portals/wps/portal/!ut/p/c5/hY7LD0	NWEEW hS-VOXkua2kwkVhLS2BDSECi8c	GCoPT 🔎 - 🔒 C 🗙 🖉 North Dakota	- 0 •	
	*Bank Routing Transit Number 291378130 What is this? *Bank Phone # 701-555-5555	*Bank Account Number 000000000 What is this? *Account Holder Name Smith	*Account Type CHECKING ACCT *Payee Provider's Name Smith		
	Billing Address Note:The billing address is equiv "Is this billing address the same Yes No Billing Location Phone Numb		re your checks will be mailed. Add Billing Location Num	bers	
	**Phone # Billing Location Contact Pers	Fa	x #^▼ Add Billing Location Contact Pers	son	
(Last Name** First Name**	Middle Initial▲▼ Phone▲▼	Ext. ^{Av} Fax ^{Av} Position ^{Av}	Email▲▼	
	■Requested Delivery Media for Re	tal Inbox 💿 Paper	vill be sent to the billing address list		

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

	Billing Location Phone Numbers
	•**Phone # Fax #**
	Add Billing Location Contact Person(s) Add Billing Location Contact Person Last Name** First Name** Middle Initial**
(Remittance Advice
	*Requested Delivery Media for Remittance Advices(RAs) © Electronic (835) © Web Portal Inbox © Paper Note: The provider can only choose one RA option. Your paper RA will be sent to the billing address listed.
	Other Details Print Suspense: Choose one of the following options if you would like to include your suspended claims on your Remittance Advice RA Sort Indicator: How would you like your Remittance Advice sorted? If none is chosen, the RA will default to the Members last name Bulletin Media : How would you like to receive your bulletins? Print Suspense RA Sort Ind Bulletin Media

Step	Action
40.	 Click the Appropriate RA option. If the individual provider is a rendering provider only, select 'Web Portal Inbox'. The RA option will be driven by the billing provider/group/entity. If the individual is a billing entity under the SSN, then the desired RA should be selected. Electronic 835 – Receive a HIPAA X12 transaction Web Portal Inbox – Received in the ND MMIS inbox Paper – Mailed to the billing address listed
Step	Action
41.	Click the Save button.
Step	Action
42.	The next section will take you through how to complete the Group Affiliation page. End of Procedure.

Group Affiliation

Procedure



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

					- 0	ſ
	ortals/wps/portal/!ut/p/c5/hY5JDoJAEEX	PwgmqQBIcQjeBRLqVUWBDSFQCkW	FBC 🔎 - 🔒 C 🗙 🎑 N	orth Dakota MMIS 🛛 🗙	Ĥ	
Provider Identifier Numbers Service Location Billing Group Affiliation Electronic Transaction Submission Ownership Exclusion / Sanction	Name of Group Practice**	North Dakota Provider Numbe	r≜▼ Effective Date▲▼	Add Grou Participating PCP**	P	
 Qualified Service Providers 	Add Group			Save Reset Car	cel	١
Help Group Affiliation To add Group Affiliation information, click the 'Add Group' button. Enter the required information and Save the form. Click anywhere on an existing row to update or delete the row.	*Name of Group Practice Name of Group Practice is required.	"North Dakota Provider Number 1450419	*Effective Date 12/10/2012 Continue>> Reset	Participating PCP		
Date Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.						
Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button to move onto the next step. If you choose to Exit Application , please save and note the Tracking Number or print						
this page so you can make updates to this application at another time.						

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

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

Electronic Transaction Submission

Procedure

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

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

*<u>Do not</u> enter the group billing information in this section on an individual application.

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

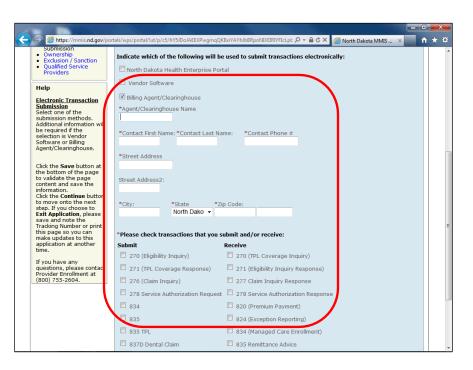
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Attps://mmis.nd.gov/po	rtals/wps/portal/lut/p/c5/hY5JDoJAEEXPwgFMFcjksm0IRgFIFNgQEIEhMiw6RPr0t 🔎 🕈 🗎 🕈 🗙 🍘 North Dakota MMIS 🛛 🖈	* ¤
Electronic Transaction Submissio	n Print Help 🗕 🗆	^
* Required Field		
Application Links • Application Tracking Number 124004 • Instructions • I dentifying Information • Licensure / Grititation • Ormbers • Service Location Billing • Group Affiliation • Electronic Transaction • Submership • Exclusion / Sanction • Qualified Service • Providers	Electronic Transaction Submission- Section 6 Providers who choose to submit claims, must be aware that payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Further, Providers must understand and agree to do the following: • Safeguard against abuse in the use of electronic claims submission • Correctly enter the claims data, montrol the data, and certly that the data entered is correct • Assure that the transmission of claims data is restricted to authonized personnel to prevent erroneous payment fib the appendence of the data, and certly that the data entered is correct • Allow the agency or any of its designees and representatives to review and copy all records, including source documents and data related to information entered through electronic claims submission • Abide by all Federal and State statutes, rules, regulations, and manuals governing North Dakota programs • Sign and adhere to all conditions of the Provider Agreement and be officially enrolled in the program to participate in electronic claims submission Indicate which of the following will be used to submit transactions electronically: • North Dakota Health Enterprise Portal • Vendor Software	E
Electronic Transaction Submission submission methods. Additional information will be required if the selection is Vendor Software or Billing Agent/Clearinghouse. Click the Save button at the bottom of the page content and save the information. Click the Continue button to move onto the next be information. Click the Continue button to move onto the next bert Application, please save and note the Tracking Number or print	Billing Agent/Clearinghouse Continue>> Reset Save Exit Application	

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

			Ð	×	
- A log https://mmis.nd.gov/port	als/wps/portal/!ut/p/c5/hY5JDoJAEEXPwgmqQ0	CaXDU1ABRSQcUNIHAKRIZEQG 🔎 – 🔒 🖒 🗙 🌈 North Dakota MMIS 🛛 🛛	ñ	* 2	ŧ
Group Amiliation Clectronic Transaction Submission Ownership Exclusion / Sanction Qualified Service Providers	Abide by all Federal and State stati Sign and adhere to all conditions of participate in electronic daims subn Indicate which of the following will be North Dakota Health Enterprise Port	utes, rules, regulations, and manuals governing North Dakota programs the Provider Agreement and be officially enrolled in the program to nission			•
Help	Vendor Software				
Electronic Transaction Submission Select one of the submission methods. Additional information will be required if the selection is Vendor Software or Billing	*Software Vendor Name *Software Name Protocol	*Version #		ſ	
Agent/Clearinghouse. Click the Save button at the bottom of the page to validate the page content and save the information. Click the Continue button	 Billing Agent/Clearinghouse Please check transactions that you s Submit 	ubmit and/or receive: Receive			
to move onto the next step. If you choose to Exit Application , please save and note the Tracking Number or print this page so you can	 270 (Eligibility Inquiry) 271 (TPL Coverage Response) 276 (Claim Inquiry) 	270 (TPL Coverage Inquiry) 271 (Eligibility Inquiry Response) 277 Claim Inquiry Response			н
make updates to this application at another time.		279 Service Authorization Response 820 (Premium Payment)			
If you have any questions, please contact Provider Enrollment at (800) 755-2604.	835 835 TPL	 824 (Exception Reporting) 834 (Managed Care Enrollment) 			
	837D Dental Claim	835 Remittance Advice			l
	 837I Institutional Claim 837P Professional Claim 	835 TPL 837			

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

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



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

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

Ownership

Procedure



Step	Action
1.	Click the Yes or No option for questions $1-4$. If Yes , complete the additional fields. If No , continue to next section.

			x
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	T. Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services?		
	Add Ownership	Ν	
	Business Name** Current ND Provider #** Medicare #** Effective Date** End Date** State**		
	Add Ownership Information Save Reset Cancer		
	*Organization's Legal Business Name *Effective Date *End Date		
	*Address *City *State *Zip North Dakota •		
	*EIN Number		
	*Please enter your NPI and/or Medicaid numbers. Indicate Medicare or Medicaid by checking a box below. *NPI # Medicaid		
	Medicare Medicaid	Ϊ	
	 *2. Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services? Yes O No 		
	 *3. Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates som of its management functions or responsibilities of providing medical care to its patients.) Yes O No 	e	

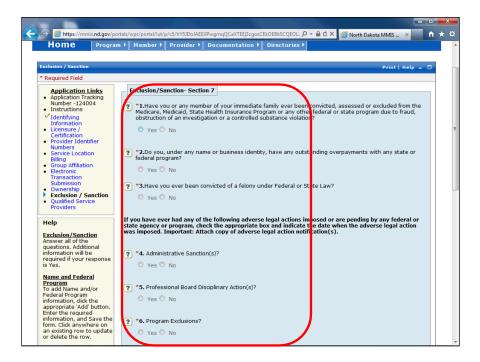
Step	Action
2.	If Yes, Enter the information into the Organization's Legal Business Name field.
Step	Action
3.	Enter the Effective Date and End Date.
Step	Action
4.	Enter the desired information into the Address field.
Step	Action
5.	Enter the desired information into the City field.
Step	Action
6.	Enter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

	ortals/wps/portal/!ut/p/c5/hY7bCoJQEEW_xS-Y0bz1eDqKQh7La-qLCKYoeQIE0q_v. 🔎 🕈 🖨 🖒 🗙 💋 North Dakota MMIS 🗴 📰 👘 🛨
Vollmber-124004 Instructions ✓ Identifying Information Licensure / Certification Provider Identifier Numbers Service Location Billing Group Affiliation	T. Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services? Ves O No System successfully saved the Information. Add Ownership
Electronic Transaction Submission	Business Name ⁴ Current ND Provider # ⁴ Medicare # ⁴ Effective Date ⁴ End Date ⁴ State ⁴ Organization 1 1450419 12/01/2012 12/31/2012 North Dakota
Qualified Service Providers	 *2. Have you ever managed or directed any organization that has billed or is currently billing Medicare or ND Medicaid services? Yes No *3. Do you have an ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/Provider contracts or delegates some of its management functions or responsibilities of providing medical care to its patients.) Yes No *4. Do any of the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice?
Help Answer all of the questions.	Continue>> Reset Save Exit Application

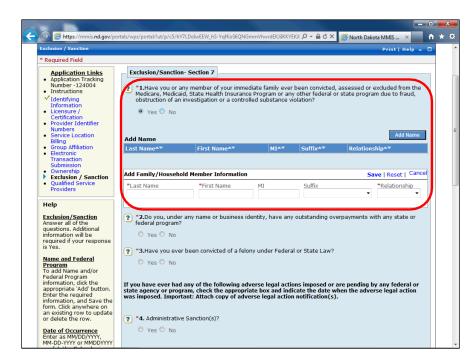
Step	Action
12.	Repeat the steps for questions 2 – 4. Answering Yes to these questions will require additional information to be completed.
Step	Action
13.	Click the Save button.
Step	Action
14.	Click the Continue>> button.
Step	Action
15.	The next section will take you through how to complete the Exclusion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

Exclusion/Sanction

Procedure

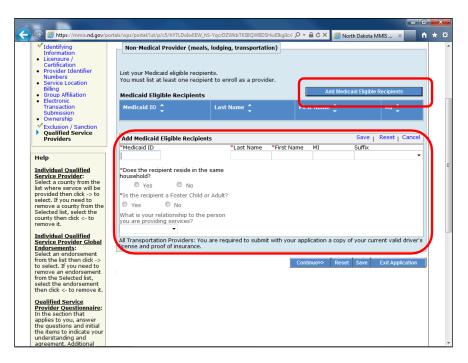


Step	Action
1.	If <u>YES</u> is answered for any question in this section, you will be required to provide additional information.
Step	Action
2.	Click the Yes or No option for questions 1 - 15.



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

Qualified Service Providers Procedure



Step	Action
1.	If not enrolling as a Non-Medical Provider (QSP, Transportation, Meals, and Lodging providers), this section can be skipped. If you did not select Qualified Service Provider as a Provider Type or one of the following Specialties: 1) Lodging 2) Provide Meals 3) Private Vehicle 4) QSP
	This Section can be skipped.
Step	Action
2.	Click the Add Medicaid Eligible Recipients button. Add Medicaid Eligible Recipients
Step	Action
3.	Enter the desired information into the Medicaid ID field.
Step	Action
4.	Enter the desired information into the Last Name field.

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

Submit Application

Procedure

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Application Links Application Tracking	Provider Agreement
Number -124004 • Instructions • Identifying	Before your application is validated, please read the Provider Agreenent, then click either the "Yes" or "No" button before you proceed to validate the application.
Information Licensure / Certification Provider Identifier Numbers	Medicaid and Basic Care Assistance Programs Provider Agreement Medicaid Program Provider Agreement Pharmacy Agreement/Medical Assistance Program PCCM Agreement EDI Tradino Partner Agreement
✓ Service Location	Register for Web Access
Billing Group Affiliation Electronic Transaction Submission	Would you like to register for Web access? If you are enrolling for multiple service locations, please provide a different User ID for each service location. Please note that if you only register for web access for one service location, you may only access data for that one location.
Ownership Exclusion / Sanction Oualified Service	Please enter a User ID of your choice and the following information for the Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords.
Providers	Registering for web access allows you to submit claims electronically and creates an online message center where you can receive letters and remittance advices.
	Yes No 'Organization Name 'Organization Description 'User ID
	Prefix *Last Name *First Name MI Suffix
	*Phone # Ext Email Address
	Validate Application
	Cick the Validate Application button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error, you will be directed to the Submit Application Step Two - Review Application page before the final application submission.
	Save Validate Application If you have any questions, please contact Provider Enrollment at (800) 755-2604.

Step	Action
1.	 Read each of the Provider Agreements that pertains to this enrollment. Medicaid Program Provider Agreement is required for <u>all</u> providers. PCCM Agreement is no longer required. The PCCM Program ended effective 12/31/2023.

Application Links Application Tracking	Provider Agre	eement					
• Instructions	Before your app button before y	plication is validated, ou proceed to valida	please read the Provider Agreeme te the application.	nt, then	click either the "Yes" or "	'No"	
 Identifying Information Licensure / Certification Provider Identifier Numbers 	Medicaid Progra	m Provider Agreeme ement/Medical Assist: nt					
 Service Location Billing 	Register for V	Web Access					
 Group Affiliation Electronic Transaction Submission 	different User II	to register for Web a D for each service loo ay only access data f	ccess? If you are enrolling for multi ation. Please note that if you only or that one location.	ple servi register f	ce locations, please prov or web access for one s	vide a ervice	
Ownership Exclusion / Sanction Oualified Service	Provider Organi	ization Administrator	e and the following information for is the person responsible for settir ition Administrator will also be resp	ng up an	d maintaining users for t	he	
Providers	Registering for where you can	web access allows yo	ou to submit claims electronically ar emittance advices	nd create	s an online message cer	nter	
	Yes No *Organization	Name	 Organization Description 		*User ID		
		Name *Last Name	 Organization Description First Name 	MI	*User ID Suffix		
	*Organization			MI			
	*Organization	*Last Name	*First Name	MI			
	*Organization	*Last Name Ext	*First Name	MI		•	
	*Organization I Prefix *Phone # Validate App Click the Validat through the app	Last Name Ext Kathering K	*First Name	errors.It	Suffix errors are found, you w you will be directed to t	rill be led the Submit	

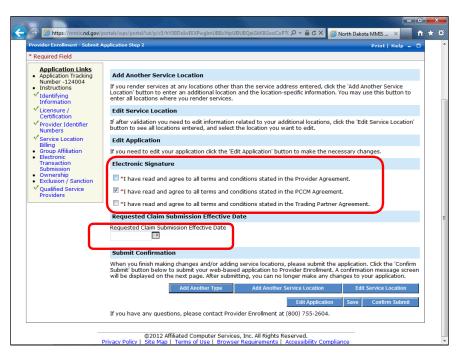
Step	Action
2.	Registering for Web Access is <u>not recommended for individual rendering</u> <u>providers billing under a group</u> . Individual providers billing independently may choose to register for web access.
Step	Action
3.	Enter the desired information into the Organization Name field.
Step	Action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



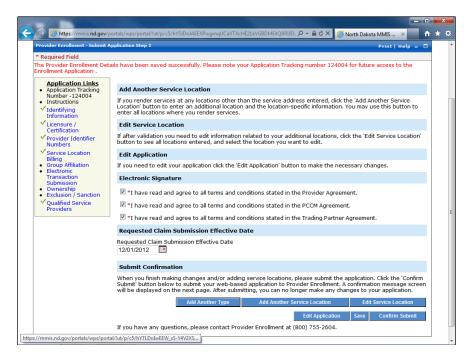
Step	Action
10.	If the User ID already exists, you will be prompted to enter a different User ID.

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Application Links Application Tracking		eement					
Number -124004 • Instructions	Before your ap	plication is validated, you proceed to validat	please read the Provider Agr te the application.	reement, then	click either the "Yes" or "No		
✓ Identifying Information ✓ Licensure / Certification ✓ Provider Identifier	Medicaid Progra Pharmacy Agre PCCM Agreeme	am Provider Agreemer ement/Medical Assista	Programs Provider Agreemen It Ince Program	t			
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Submission • Ownership • Exclusion / Sanctior • Oualified Service	Provider Organ	ization Administrator	e and the following information is the person responsible for tion Administrator will also be	r setting up an	d maintaining users for the		
Providers		web access allows yo receive letters and re	ou to submit claims electronic mittance advices.	ally and create	es an online message center	r	
	🖲 Yes 🔘 No						
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	701-555-5555	;					
	Validate App	lication					
	Click the Valida through the ap	te Application button l plication and instructe	below to check your applicati d to correct each error. If th ation page before the final a	ere is no error	you will be directed to the		
		If yo	u have any questions, pleas	e contact Prov	Sa e Validate Applicati ider Sprollmont at (200) 755		J
https://mmis.nd.gov/portals/wps	/portal/!ut/p/c5/hY5BDoIwl						

Step	Action
11.	Click the Validate Application button. This will check the application for errors.
	Validate Application



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



Step	Action
15.	Review the application for accuracy and completeness before submitting the application.
Step	Action
16.	Add Another Type and Add Another Service Location should <u>never</u> be used on an individual application. If the individual has more than one provider type, then a separate application is required. If the individual practices at multiple locations, then use the group affiliations page to associate all locations.
Step	Action
17.	If you click the Confirm Submit option, you will not be able to make any further edits to the application.
Step	Action
18.	Click the Confirm Submit button if you have no edits or updates to make to the application. Confirm Submit

Required Field Tank you for submitting your application on-line. In order to fully process your application the required documents listed below must be mailed to DHS. Once all documents have been received and your application reviewed you will be notified via mail with the application decision. Dou may check the status of your application at any time, through the Application Status function located on the main Enrollment home page or by intacting Provider Enrollment Services at the number listed below, and providing your Application Tracking Number. Application Tracking Number 124004 Tracking Provider Enrollment Services at the number listed below, and providing your Application Tracking Number. Application Tracking Number 124004 Tracking Provider Enrollment Services at the number listed below, and providing your Application Tracking Number. Application Tracking Number 124004 Tracking Provider Enrollment Services at the number listed below, and providing your Application Tracking Number. Print and Review The Print Application Intracking Number: 124005 The Print Application button may be used to print a copy of the application. This copy is for your records only and should not be sent to DHS. The application button may be used to print a copy of the application. This copy is for your records only and should not be sent to DHS. Additional documents may be required to be sent in as attachments to your application depending on your provider type. Print the Document Requirements Checklist to identify the supplemental information by provider type that is needed to finalize your application. North Dakota Department of Human Services Provider Enrollment GOU E Boulevard Avenue Dept 325 Bismarck ND 58505-0250			- 0
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	Once the required document has be	en printed, click the Exit Application button to return to the ND Provider Enrollment Homepage	
you have any questions, please call DHS at (800) 755-2604.		Print Application Exit Applica	tion
	f you have any questions, please call	DHS at (800) 755-2604.	

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

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		partment of Human Services ider Enrollment Application			
Submitted on: December 11, 2	012				
Application Tracking Number	124004				
Trading Partner Application T	racking Number: 124005				
	Identifying Informatic	on-Section 1			
Last Name: Smith	First Name: Tim	MI:			
Suffix:	Title:	Date of Birth: 12/15/1	1960		
Gender: Male	C an information about date of	f birth and gender be a vailable to clien	ts? Yes		
\$\$N: 505555555					
Current and/or pievious ND P	Current/Previous N rovider numbers: 000012345	D Provider#			
Num and an and a second	Previous N ames in the past five years?: No	ames			
	it Name:				
	Licensure and Certificat	tion – Section 2			
Provider Type: Physicians					

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

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Step	Action
22.	Click the Exit Application button.
	Exit Application

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Step	Action
23.	Click the OK button.
Step	Action
24.	
	End of Procedure.