NORTH Dakota Be Legendary.

Health & Human Services

GROUP PROVIDER ATTESTATION

TARGETED CASE MANAGEMENT SERVICES LONG TERM CARE

_____ _____

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 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 NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956, ATT: NDM Provider Enrollment