NORTH Dakota Be Legendary.

Health & Human Services

INDIVIDUAL ATTESTATION

LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

_____ _____

Individual Name (printed) NPI

Please note that you have requested enrolling as a Case Management individual provider (practitioner); 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.

I have met the following requirements:
(CHECK ALL THAT APPLY):

☐ 1. I am a Developmental Disabilities program manager

AND

☐ a. I am a Qualified Intellectual Disabilities Professional (QIDP)

OR

☐ b. I have at least 1 year of experience as a Developmental Disabilities Case Manger in the North Dakota Department of Human Services.

I attest that I met the above requirements on _____ (Month/Day/Year).

_____ _____

Signature of Enrolling Individual Date

Provider Facility/Organization to complete next page.

NORTH Dakota Be Legendary.

Health & Human Services

INDIVIDUAL ATTESTATION

LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

I attest that the practitioner mentioned above has met the established criteria as indicated above.

_____ Provider Facility/Organization Name

_____ Street Address

_____ City, State, Zip Code

_____ _____

Supervisor Signature Date

_____

Printed Name of Supervisor

Please sign and return by Email to NDMedicaidEnrollment@noridian.com or by fax to 701-433-5956, ATT: NDM Provider Enrollment