NORTH Dakota Be Legendary.

Health & Human Services

Physical Therapist Individual Application Requirements

Type of Application: **Date submitted:** _____

- ◯ **New Application**
- ◯ **Revalidation**
- ◯ **Reactivation**

Section 1: Provider Information

Application Tracking # (New Applications only):	
Current Medicaid ID Number (only used for Revalidation and Reactivation):	
Provider Name:	
Individual NPI #:	
Service Address:	
Billing Address:	
Mailing Address:	
Facility Phone:	
Contact person / Title:	
Contact phone number:	
Contact email:	
Provider phone number:	
Provider email:	

◯ **Enrolled Billing Group (Add Affiliation Below)**

Medicaid Provider ID:	Billing Group Name:	Facility Phone:

◯ **Unenrolled Billing Group. Please provide Application Tracking Number and/or NPI (if applicable)** _____

◯ **No Billing Group – Practitioner is enrolling as an Ordering, Referring, or Prescribing provider only and will not have affiliations with a billing group. Check this option only if claims will not be submitted for services rendered by this practitioner – only enrolling to order, refer or prescribe.**

Provider Type – 022- Respiratory, Developmental, Rehabilitative & Restorative Service Providers
Specialty 123-Physical Therapy
Taxonomy 225100000X

☐ **This application is not associated with an emergency service. We are requesting an effective date of:**

_____

☐ **This application is associated with emergent care. We are requesting an effective date of:**

_____

***ND Medicaid may consider a retroactive enrollment effective date that exceeds ninety (90) days but not to exceed 365 days from the date of service for situations involving emergent care provided to a member. If the application involves an emergency service, an explanation on why enrollment was not able to be submitted within ninety (90) days from the date of service and medical notes must be sent with the application packet. If you do not submit this information, a date beyond ninety (90) days of receipt of a completed application may not be approved.**

Section 2: Required Documents

1. Physical Therapist Application Requirements

2. Copy of license

3. SFN 615 - Medicaid Program Provider Agreement
   **Must be signed and dated by the Individual Provider who is applying*

Section 3: Networks

☐ Medicaid Fee For Service (traditional
☐ Medicaid) PACE
☐ Medicaid Expansion MCO

***Providers electing expansion services must also contact Blue Cross Blue Shield North Dakota (BCBSND) at providercontracting@bcbsnd.com to enroll with Medicaid Expansion. For additional questions, refer to the following: Medicaid Expansion Provider Resources | BCBSND.

Application may be submitted by:
Email: NDMedicaidenrollment@noridian.com
Fax: 701-433-5956 ATTN: NDM Provider Enrollment
Mail: Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

For questions concerning Provider Enrollment, please contact (877) 328-7098 (tollfree) or (701) 328-7098. Live support 8 a.m. - 5 p.m. CT, Monday – Friday.