North Dakota Medicaid
Individual Revalidation Checklist

You must fill out the checklist entirely and attach the documents indicated on the checklist along with signed signature pages for the packet to be considered complete.

The department does not retain incomplete documents. If this packet is incomplete when it is received, the entire packet will be deleted and you will receive an email notification at the contact email address entered on the checklist.

Published by:
Medical Services Division
Provider Enrollment
600 E. Boulevard Ave., Dept. 325
Bismarck, ND 58505

December 2022

Individual Revalidation Checklist

Have Questions?
Click Here for FAQs and More Resources

All Fields are Required unless specifically marked as not required

Medicaid ID #	
Provider Name	
NPI	

*NPI Not Required for NEMT (Non-Emergent Medical Transportation) Providers

Primary Service Address	
Billing Address	

*Billing Address for NEMT providers is where paper checks will be mailed. Please make sure this address is entered correctly.

Mailing Address	**Street**					
	City		**State**		**Zip**	
Facility Phone						

Contact Person			
Phone		**Ext**	
Email			

LAC (taxonomy 101YA0400X) ONLY: Please indicate which ASAM levels are provided by your program. At such time as your program decides to provide any additional ASAM levels, you must inform the Department in advance and submit the license which covers the ASAM levels provided. Any levels not found in the list below are not covered by ND Medicaid at this time.

ASAM Levels: 1 2.1 2.5 3.1 3.2 3.5 3.7 No ASAM

RN to Schools ONLY:
Is this RN providing Rehab services?
YES NO

TCM ONLY:
What type of TCM services are you billing for this individual? Check all that apply
If you are not sure, please use the links to review the policy for each type of TCM service

Child Welfare High Risk Pregnant Women Long Term Care SMI/SED

Physical Therapists ONLY:
Are you revalidating this individual to provide physical therapy services at any other locations at this time?
YES NO

If yes, attach a list with the addresses and phone numbers of all service locations (locations must already be enrolled under a group Medicaid ID)

Please Note: Any service locations (including the primary) that are not already enrolled under the group record will not be added to the record or considered for revalidation. Service Address phone numbers cannot be credentialing staff phones; instead, they must be phones located at the location where the services are provided. **If this Physical Therapist is reported as not working there or unknown by the phone number listed for the service address, the revalidation will be incomplete and the affiliation/s and record may be terminated.**

The documents requested below must be returned to the Department in order to revalidate your enrollment				
Required Documents	**Submitted**			
Fax/Email Coversheet				
This Checklist				
License/Certification		**Expires:**		
DEA (If Applicable)		**Expires:**		
SFN 615 (12-2022)				
LAC ONLY: **Facility ASAM License**		**Expires:**		
LAPC ONLY: **LAPC Attestation (7-2022)**				
LBSW ONLY: **LBSW Attestation (7-2022)**				
LMSW ONLY: **LMSW Attestation (7-2022)**				
BMS ONLY: **BMS Attestation (7-2022)**				
MHT ONLY: **MHT Attestation (7-2022)**				
RN providing Rehab ONLY: **RN Rehab Attestation (8/2021)**				
RN to Schools ONLY: **RN Schools Attestation (8/2021)**				
TCM ONLY: **See TCM Requirements**				
NEMT ONLY: **W9 (10-2018)**				
NEMT ONLY: **Driver's License**		**Expires:**		
FOSTER NEMT ONLY: **Foster License**		**Expires:**		
FOSTER NEMT ONLY: **SFN 904 or Letter****		**Foster NEMT Letter must support why you feel your foster child(ren) qualifies as having medical needs that are "above and beyond" what would be considered a normal frequency		

Proof of Insurance is not required for any application. If proof of insurance is submitted with an application, it will be deleted from the file. It remains the provider's responsibility to ensure that the necessary insurance is in place, but proof of insurance is not required to be submitted for any application.

NEMT ONLY: This attestation is only for NEMT (Non-Emergent Medical Transportation) Providers

I, the undersigned applicant (driver) affirm that the vehicle used to provide transportation is in good operating order, including the brakes, lights, and tires. I understand and agree that the State of North Dakota shall not be liable for any damages which may arise out of or result from the operating condition of the vehicle.

Printed Name			
Signature		**Date**	

Networks		
What Network or Networks is this provider enrolling to participate in?		
Selecting any of the managed care organization (MCO) boxes (PACE or Expansion) DOES NOT automatically enroll a provider to render or bill services for the MCO. As all benefits and claims are administrated by the MCO, in order to provide and bill these MCO services, all providers must be contracted directly with the applicable MCO.		
Medicaid Fee For Service (Traditional Medicaid)	Medicaid Expansion MCO	PACE

Submit Your Revalidation to North Dakota Medicaid, Provider Enrollment:

1. By regular Email: NDMedicaidEnrollment@noridian.com
2. Fax – Providers may fax the required documentation to (701) 433-5956

Revision 12/16/2022

FAQs and Resources

Am I required to revalidate?

If you have received notice that your revalidation is due, or you have checked the ND Medicaid Revalidation Website and your name and NPI are on the list - Yes, you are requried to revalidate. Revalidations are required to be performed for all provider records, regardless of provider type, at least every five years (this includes ordering or referring physicians or other professionals) per 42 CFR 455.414. The Department may, at its discretion require revalidation on a more frequent basis.

What Documents are Actually Required?

All documents listed on the revalidation checklist are required. If a document is not required for all providers, it is noted specifically as not required next to the document name in the checklist.
Additionally, all fields in all Sections on the checklist must be completed.
All documents (correctly completed) must be recieved by your revalidation due date.

What happens if I do not send in all the documents (correctly completed) by the date indicated in my notification?

If all required documents (correctly completed) are not received by your revaldiation due date, your record with North Dakota Medicaid will be terminated. Any claims with dates of service after your due date will not pay. You will receive an email notification of the termination to the email address where the original notification

If my record has been terminated for no revalidation, how can I reactivate my record?

Once terminated, submit the requested documentation/information within 120 days from the termination notice to reactivate your record without a gap in your enrollment. If the documentation (correctly completed) is received after 120 days, your record will reflect a gap in the enrollment.

What is an NPI?

Click Here to find more information about NPIs.

What is a North Dakota Medicaid ID?

The North Dakota Medicaid ID is a unique identifier the system assigns to each application once it reaches the "Approved Status". It is 7 digits and replaces your Application Tracking Number. Once assigned a 7 digit Medicaid ID, please include the ID in every correspondence with the Department regarding that record.

Please Note: If you were enrolled in our old system (prior to 2013 - often called "Legacy", please do not use your previous Medicaid ID. The Legacy numbers had place holding zeros and 4-5 numbers at the end. Legacy numbers have been replaced by the new 7 digit numbers as your Medicaid ID. Use of the Legacy numbers on documents may delay your update requests.

Am I required to use the Provider Enrollment Fax/Email Coversheet or can I use my own?

A coversheet must be submitted with all documents sent to the Department in order to identify the purpose of the documents. The Provider Enrollment Fax/Email coversheet is not required, as long as your coversheet has the following elements: 1. Provider Name; 2. NPI; 3. Medicaid ID or Application Tracking Number; 4. Name of the person in your organization who should be contacted if there are any questions about the documents submitted; 5. Phone number for the contact; 6. Email address for the contact; 7. Purpose you submitted the documents (application, revalidation, affiliation etc.). A sample list of reasons for document submission can be found on the Provider Enrollment Fax/Email Coversheet for reference.

Whose NPI and Medicaid ID goes on the SFN 615?

The NPI and Medicaid ID of the revalidating individual go on the SFN 615. As this revalidation is for the individual practitioner, do not put the Medicaid ID or NPI of the billing group.

Where do I submit the Documents?

1. **Standard Email – NDMedicaidEnrollment@noridian.com**
2. **Fax – Providers may fax the required documentation to (701) 433-5956**

Links:

Provider Enrollment Website

Revision 12/16/2022

North Dakota Department of Human Services

What is an NPI?

"The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes." – Quoted from CMS website: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html

Please visit CMS.gov to obtain more information about NPIs, or use the link above to access their NPI page.

NPIs are obtained and maintained on the "NPPES" website: https://nppes.cms.hhs.gov/#/

Coversheet for Email or Fax
Provider Enrollment

Date Submitted	
Medicaid ID/Application Tracking Number	
Provider Name	
NPI #	

Contact Person			
Phone		Ext	
Email			

Number of Pages Submitted (Including Email/Fax Coversheet):	

Documents Submitted For (Check All That Apply):

New Application	Revalidation
Affiliation	Reactivation
Taxonomy Update	Termination
Change of Ownership	Name Change
Address Change	Change of Managing Employees/Board Members
Tax ID Change	Contact Information Change
EFT Request/Update	NPI Change
Update to Email/Fax Submitted on:	Earlier Fax did not go through. Earlier Fax Submitted on:

Fax to 701-433-5956 ATTN: NDM Provider Enrollment

North Dakota Medicaid Enrollment Attestation for Licensed Associate Professional Counselor

ND Medicaid enrolls LAPC's as individual providers to render Mental Health Rehabilitative services and bill under their own NPI. LAPC's are not able to bill for services from the professional fee schedule that are reserved for higher licensed practitioners.

______________________________ ______________________________

Practitioner Name (printed) **NPI**

As a Licensed Associate Professional Counselor (LAPC) enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I may only provide the following service(s) to Medicaid Members:

CHECK ALL THAT APPLY:

- Screening, Triage, and Referral Leading to Assessment
- Crisis Intervention
- Behavioral Health Counseling and Therapy (QRTP and Therapeutic Foster Care Only)
- Individual or Group Counseling
- Intensive In-Home for Children
- Skills Restoration
- Skills Integration
- Assessment for Alleged Abuse and/or Neglect and Recommended Plan of Care (*formerly known as Forensic Interview*)

I attest that I will provide the above service/s in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

______________________________ ______________

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above will only provide the service(s) marked above in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

______________________________ Supervisor Name
______________________________ 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, Attention: NDM Provider Enrollment

Revision Date 7/1/2022

North Dakota Medicaid Enrollment Attestation for Licensed Baccalaureate Social Worker

ND Medicaid enrolls LBSW's as individual providers to render Mental Health Rehabilitative services and bill under their own NPI. LBSW are not able to bill for services from the professional fee schedule that are reserved for higher licensed practitioners.

Practitioner Name (printed) ______________________________ **NPI** ______________________________

As a Licensed Baccalaureate Social Worker (LBSW) enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I may only provide the following service(s) to Medicaid Members:

CHECK ALL THAT APPLY:

- Screening, Triage, and Referral Leading to Assessment
- Crisis Intervention
- Behavioral Health Counseling and Therapy (QRTP and Therapeutic Foster Care Only)
- Individual or Group Counseling
- Intensive In-Home for Children
- Skills Restoration
- Skills Integration
- Assessment for Alleged Abuse and/or Neglect and Recommended Plan of Care *(formerly known as Forensic Interview)*

I attest that I will provide the above service/s in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

____
Signature of Enrolling Practitioner

____
Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above will only provide the service(s) marked above in accordance with the North Dakota Behavioral Health Services Manual.

______________________________ Supervisor Name
______________________________ 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, Attention: NDM Provider Enrollment

North Dakota Medicaid Enrollment Attestation for Licensed Master Social Worker

ND Medicaid enrolls LMSW's as individual providers to render Mental Health Rehabilitative services and bill under their own NPI. LMSW's are not able to bill for services from the professional fee schedule that are reserved for higher licensed practitioners.

Practitioners Name (printed) ______________________ **NPI** ______________________

As a Licensed Master Social Worker (LMSW) enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I may only provide the following service(s) to Medicaid Members:

CHECK ALL THAT APPLY:

- Screening, Triage, and Referral Leading to Assessment
- Behavioral Assessment
- Crisis Intervention
- Behavioral Health Counseling and Therapy (QRTP and Therapeutic Foster Care Only)
- Individual or Group Counseling
- Intensive In-Home for Children
- Skills Restoration
- Skills Integration
- Assessment for Alleged Abuse and/or Neglect and Recommended Plan of Care *(formerly known as Forensic Interview)*

I attest that I will provide the above services in accordance with the North Dakota Behavioral Health Services Manual.

______________________ Signature of Enrolling Practitioner

______________________ Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above will only provide the service(s) marked above in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

______________________ Supervisor Name
______________________ 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, Attention: NDM Provider Enrollment

Revision Date 7/1/2022

NORTH DAKOTA MEDICAID ENROLLMENT ATTESTATION FOR BEHAVIOR MODIFICATION SPECIALIST

____________________________ Practitioner Name (printed)

______________________ NPI

As a Behavior Modification Specialist (BMS) enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I may only provide the following service(s) to Medicaid Members:

CHECK ALL THAT APPLY:

Screening, Triage, and Referral Leading to

Assessment Crisis Intervention

Skills Restoration

Skills Integration

Behavioral Intervention

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 attest that I have met the following requirements:

CHECK ALL THAT APPLY:

1. ______ I have a Master's degree in psychology, social work, counseling, education, child development and family science, human services or communication disorders.

OR

2. ______ I have a Bachelors' degree in psychology, social work, counseling, education, child development and family science, human services or communication disorders.

AND

a. ______I have two years of work experience in the respective discipline. The work experience is in a professional setting and supervised by a licensed practitioner in a related field.

I attest that I will provide the above services in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

_____________________________________ Signature of Enrolling Practitioner

________________ Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above will provide the above services in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

______________________________________ Supervisor Name
______________________________________ Provider Facility/Organization Name
______________________________________ Street Address
______________________________________ City, State, Zip Code

____ Supervisor Signature

________________ Date

Please sign and return by Email to NDMediciaidEnrollment@noridian.com or by fax to

701-433-5956, Attention: Provider Enrollment

NORTH DAKOTA PROVIDER ENROLLMENT ATTESTATION FOR MENTAL HEALTH TECHNICIAN

______________________________ ________________________

Practitioner Name (printed) NPI

As a Mental Health Technician (MHT) enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I may only provide the following service(s) to Medicaid Members:

CHECK ALL THAT APPLY:

Skills Integration

I attest that I will provide the above services in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

____ ________________

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above will provide the above services in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

____ Supervisor Name

____ Provider Facility/Organization Name

____ Street Address

____ City, State, Zip Code

____ __________________

Supervisor Signature Date

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

NORTH DAKOTA PROVIDER ENROLLMENT ATTESTATION FOR REGISTERED NURSE FOR REHABILITATIVE SERVICES

Practitioner Name (printed) ____________________

NPI ____________________

As a Registered Nurse (RN) enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I may only provide the following service(s) to Medicaid Members:

CHECK ALL THAT APPLY:

- Screening, Triage, and Referral Leading to Assessment
- Nursing Assessment and Evaluation
- Skills Restoration

I attest that I will provide the above services in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

Signature of Enrolling Practitioner ____________________

Date ____________________

Provider Facility/Organization to complete:

I attest that the practitioner mentioned above will provide the above services in accordance with the North Dakota Medicaid Behavioral Health Services Manual.

____________________ Supervisor Name

____________________ Provider Facility/Organization Name

____________________ Street Address

____________________ City, State, Zip Code

Supervisor Signature ____________________

Date ____________________

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

Medicaid Provider Enrollment Attestation
Registered Nurse Services Billed By Schools

Practitioner Name (printed) ______________________ NPI ______________________

As a Registered Nurse enrolling to provide nursing services under the North Dakota Individualized Education Program (IEP) Medicaid Services Billed By Schools policy, I attest that I understand the following requirements:

- ______ Nursing services require a written order that is documented in the Medicaid-eligible student's IEP (written order can be from a physician, nurse practitioner, or physician assistant).
- ______ Nursing services may only be billed to ND Medicaid for Medicaid-eligible students with complex medical needs.
- ______ Non-Covered Services include:
    1. Services provided that are not documented in the Medicaid-eligible student's IEP.
    2. Services not authorized by written order.
    3. Services that are not provided directly to the child such as attendance at staff meetings, IEP meetings, staff supervision, member screening, development and use of instructional text and treatment materials.
    4. Communications between the provider and child that is not face-to-face.
    5. Population screenings such as lice checks.
    6. Services considered experimental or investigational.
    7. Services considered educational or instructional in nature.
    8. Medication administration.

____
Signature of Enrolling RN

____
Date

School to complete:

I attest that the practitioner named above and the school billing the service have both reviewed the requirements mentioned above and will bill nursing services in accordance with the North Dakota Individualized Education Program Medicaid Services Billed By Schools policy.

______________________________ Supervisor Name
______________________________ School Name
______________________________ Street Address
______________________________ City, State, Zip Code

____
Supervisor Signature

____
Date

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

Revision Date 8/5/2021

Requirements for Individual Targeted Case Managers (TCMs)

Child Welfare

(Link to Policy)

1. **Wraparound Certificate**
   AND
2. **Degree***

**Degree must be Bachelor's or above and be in one of the following fields:*

1. Social Work
2. Psychology
3. Sociology
4. Counseling
5. Human Development
6. Elementary Education
7. Early Childhood Education
8. Special Education
9. Child Development and Family Science
10. Human Resource Management (human-service track)
11. Criminal Justice
12. Human Services - Child & Family Welfare

High Risk Pregnant Women and Infants

(Link to Policy)

1. **Social Work Master's Degree**
   OR
2. **Social Work License + Individual High Risk Pregnant Women and Infants Attestation (Option #1 checked)**
   OR
3. **RN License**
   OR
4. **LPN License + Individual High Risk Pregnant Women and Infants Attestation (Option #1 checked)**
   OR
5. **Bachelor's Degree + Individual High Risk Pregnant Women and Infants Attestation (Option # 2 checked - health educator)**
   OR
6. **Licensed Registered Dietitian License or Licensed Nutritionist License**
   OR
7. **Individual High Risk Pregnant Women and Infants Attestation (Option #3 checked)**

Long Term Care

1. **Individual Long Term Care Attestation**
   AND
2. **Social Work License***

**Social Work License is not required if the provider can attest to the requirements on the Individual Long Term Care Attestation and submit the completed Attestation.*

SMI/SED

(Link to Policy)

1. **Individual SMI/SED Attestation***

**Degree must be Bachelor's or above and be in one of the following fields:*

1. Social Work
2. Psychology
3. Nursing
4. Sociology
5. Counseling
6. Human Development
7. Special Education
8. Child Development and Family Science
9. Human Resource Management (human-service track)
10. Criminal Justice
11. Occupational Therapy
12. Communication Science/Disorders
13. Vocational Rehabilitation
14. Human Services - Child & Family Welfare
15. Addiction Studies (Requires Transcripts unless from Minot State University)
16. Addiction Counseling

INDIVIDUAL ATTESTATION

TARGETED CASE MANAGEMENT SERVICES TO HIGH RISK PREGNANT WOMEN AND INFANTS

______________________________ ______________________
Practitioner 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 requirement:

(CHECK ALL THAT APPLY):

1. ______ I have at least six months of case management experience.

OR

2. ______ I am qualified to practice as a Health Educator and have at least six months of case management experience.

OR

3. ______ I have at least five years of experience working with high risk pregnant women in a supervised, clinical setting.

I attest that I met the above requirement on ________________(Month/Day/Year).

____

Signature of Enrolling Practitioner

____

Date

Provider Facility/Organization to complete:

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

Revision Date 4/28/2021

INDIVIDUAL ATTESTATION
LONG TERM CARE TARGETED CASE MANAGEMENT SERVICES

______________________________ ______________________
Practitioner 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 Practitioner Date

Provider Facility/Organization to complete:

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

Revision Date 4/28/2021

INDIVIDUAL ATTESTATION

TARGETED CASE MANAGEMENT SERVICES
SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS EMOTIONAL DISTURBANCE (SED)

______________________ ______________________

Practitioner Name (printed) NPI

Please fill out this form to confirm required training or background requirements for enrollment as a Targeted Case Management individiual provider (practitioner). Requirements are per Medical Services Division policies or Medicaid State Plan requirements.

I meet the following requirements: CHECK ALL THAT APPLY

Have a bachelor's degree AND two years of experience working with special polulation groups[1] in a direct care setting,

a. Please list special population group or groups you have worked with:

____, OR

Have a master's degree, OR

Have at least five years of experience working with individuals with SMI/SED in a supervised, clinical setting.

I attest that I met the above requirement on ________________ (Month/Day/Year)

______________________________ ______________

Signature of Enrolling Practitioner Date

Provider Facility/Organization to complete:

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

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[1]Special population groups include nursing home or assisted living residents, youth in psychiatric treatment centers or residential facilities, individuals in substance use treatment facilities, individuals in mental health/substance use facilities, and experience working in hospitals with youth and/or adults with serious mental illness or serious emotional disturbance. This list is not exhaustive.