MTM PROVIDER ENROLLMENT APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1105 (4-2016)

Directions to MTM Provider: Please complete this form and fax it to 701-328-1544, Attention: Pharmacy.

MTM Provider Name			
Please list your typical pharmacist duties			
MTM Provider License Number			
Place of Business/Address	City	State	ZIP Code
Business Telephone Number	Business Email Address		
What do you intend to provide MTM services for? ☐ Rescue Inhaler Usage/Asthma ☐ Hepatitis C Direct Acting Antivirals ☐ Both			
MTM Provider Signature		Date	

For INITIAL Enrollment:

Attached Documentation Required:

- A current active North Dakota State license
- Printouts and/or screenshots of outcomes tracking and reporting that meets MTM documentation requirements
- A printout from CPE Monitor of CE that meets requirements

Electronic MTM Documentation System

How will you access a patient's Medical Record?

Please describe the location of MTM visits (meeting privacy and space requirements).

Please briefly describe your patient care and plan development process.

For RENEWAL Enrollment:

Attached Documentation Required:

- A print out from CPE Monitor of CE that meets requirements

☐ I verify that I continue to meet the requirements outlined in the ND Medicaid MTM provider manual to provide MTM services.