Medicaid Provider Enrollment Attestation
Licensed Baccalaureate Social Worker

Practitioner Name (printed) ______________________________ NPI ______________________________

As an LBSW enrolling to provide services under the North Dakota Rehabilitative Services State Plan, I attest that I provide only the following service/s:

CHECK ALL THAT APPLY

- ☐ Individual Counseling
- ☐ Crisis Intervention
- ☐ Intensive In-Home for Children
- ☐ Screening, Triage, and Referral Leading to Assessment
- ☐ Skills Integration

I attest that I will provide only the above service/s in accordance with the North Dakota Rehabilitative Services State Plan.

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 Rehabilitative State Plan.

______________________________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 dhsenrollment@nd.gov or by fax to 701-328-4030, Attention: Provider Enrollment