NON-EMERGENT MEDICAL TRANSPORTATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 620 (Rev. 1-2023)

Clear Fields

Disclosure of your Taxpayer Identifying Number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

Name (as it appears on your Social Security Card)	Gender ☐ Male ☐ Female	Date of Birth
Company Name (As it is reported to the Internal Revenue Service)	Telephone Number	Email Address

Mailing Address	City	State	ZIP Code
Street Address	County of Residence/Business	Taxpayer Identifying Number (i.e., SSN, EIN)	

Type of service you are providing

☐ Lodging ☐ Transportation (indicate one below):

☐ Individual/Volunteer ☐ Commercial (indicate one below):

☐ Taxi ☐ Stretcher

☐ Wheelchair ☐ Other (specify): _____

PROVIDER IDENTIFYING INFORMATION

Are you, or have you been, previously enrolled as a Medicaid provider in another state? ☐ Yes ☐ No	Previous State
Have you ever used any previous names in the past five years? ☐ Yes ☐ No	If Yes, List Previous Names

THIS SECTION MUST BE COMPLETED BY APPLICANT AS A REQUIREMENT FOR PROCESSING

Will you be transporting any recipients related to you? ☐ Yes ☐ No	If yes, indicate the relationship to you.
If Yes, do they live in the same household? ☐ Yes ☐ No	If so, is the recipient under (provide documentation to support selection) ☐ Kinship ☐ Guardianship ☐ Foster Care ☐ Other

Languages Supported (Check all that may apply)

☐ Albanian	☐ Chinese (Mandarin)	☐ German	☐ Korean	☐ Sign Language	☐ Taiwanese
☐ Arabic	☐ Czech	☐ Greek	☐ Laotian	☐ Spanish	☐ Turkish
☐ Bangla	☐ English	☐ Hindi	☐ Navajo	☐ Stavic	☐ Ukrainian
☐ Bosnian	☐ Farsi	☐ Indian	☐ Portuguese	☐ Swahili	☐ Vietnamese
☐ Cambodian/Kampuchean	☐ Filipino	☐ Italian	☐ Romanian	☐ Syrian	☐ Other_____
☐ Cantonese	☐ French	☐ Japanese	☐ Russian	☐ Tagalog	

Define your services area by counties served, or by distance from your location

☐ Adams	☐ Dickey	☐ Hettinger	☐ Mountrail	☐ Sargent	☐ Ward
☐ Barnes	☐ Divide	☐ Kidder	☐ Nelson	☐ Sheridan	☐ Wells
☐ Benson	☐ Dunn	☐ LaMoure	☐ Oliver	☐ Sioux	☐ Williams
☐ Billings	☐ Eddy	☐ Logan	☐ Pembina	☐ Slope	☐ Out-of-State
☐ Bottineau	☐ Emmons	☐ McHenry	☐ Pierce	☐ Stark	☐ Within 10 Miles
☐ Bowman	☐ Foster	☐ McIntosh	☐ Ramsey	☐ Steele	☐ Within 25 Miles
☐ Burke	☐ Golden Valley	☐ McKenzie	☐ Ransom	☐ Stutsman	☐ Within 50 Miles
☐ Burleigh	☐ Grand Forks	☐ McLean	☐ Renville	☐ Towner	☐ Within 100 Miles
☐ Cass	☐ Grant	☐ Mercer	☐ Richland	☐ Trail	☐ Within 500 Miles
☐ Cavalier	☐ Griggs	☐ Morton	☐ Rolette	☐ Walsh	☐ Within 999 Miles

Is this location wheechair accessible? ☐ Yes ☐ No	Provider Website	
Do you provide after-hours services? If yes, enter Telephone Number. ☐ Yes ☐ No		After-Hours Contact Telephone Number
Is this provider TDD/TYY equipped? If yes, enter Telephone Number. ☐ Yes ☐ No		TDD/TTY Telephone Number
Do you wish to be excluded from public Provider searches? ☐ Yes ☐ No		

REMITTANCE ADVICE

Request Delivery Media for Remittance Advices (RA's) (choose one of the following methods)

☐ Electronic (835)

☐ Web Portal Inbox (online-downloadable)

OWNERSHIP INFORMATION

1. Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid services?

☐ Yes - Complete the following information for each organization that you had an ownership interest of 5% or more in the last 10 years

☐ No - Skip to next question

Attach separate document, if necessary

Organization's Legal Business Name			Effective Date
Address			End Date
City	State	ZIP Code	Medicare Number

2. Have you ever managed or directed any organization that has billed or is currently billing Medicare or North Dakota Medicaid Services?

☐ Yes - Complete the following information for each organization that this owner managed or directed in the last 10 years

☐ No - Skip to next question

Attach separate document, if necessary

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Organization's Legal Business Name			Effective Date	End Date
Address			Current ND Provider ID	EIN
City	State	ZIP Code	Date of Birth	Social Security Number
NPI Number	NPI Number		Medicare Number	

3. Do you have ownership interest of 5% or greater in a subcontractor for your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients).

☐ Yes - Complete the following information. Attach separate document, if necessary ☐ No - Skip to next question

Name of Subcontractor		State	ZIP Code
Address	City	State	ZIP Code

OWNERSHIP INFORMATION CONTINUED

4. Do you or the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice?

☐ Yes - Complete the following information. Attach separate document, if necessary ☐ No - Skip to next question

Name	Relationship
Name of Subcontractor	

Address	City	State	ZIP Code

EXCLUSION/SANCTION INFORMATION

1. Have you or any member of your immediate family ever been convicted, assessed, or excluded from the Medicare, Medicaid, State Health Insurance Program, or any other state program due to fraud, obstruction of an investigation or a controlled substance violation?

☐ Yes ☐ No If yes, provide information about the family or household member(s) below:

Last Name, First Name, MI	Relationship

2. Do you, under any name or business identity, have any overpayments with any federal or state programs?

☐ Yes ☐ No If yes, provide information about the family or household member(s) below:

Name of Federal/State Program	Name or Business Identity

3. Have you ever been convicted of a felony under Federal or State Law?

☐ Yes ☐ No If yes, add appropriate documentation pertaining to the situation.

Date of Occurrence:

Have you ever had any of the following adverse legal actions imposed or are pending by any federal or state agency or program. Check the appropriate box and indicate the date when the adverse legal action was imposed. Important: Attach copy of adverse legal action notification(s).

			Date of Occurrence
4. Administrative Sanction?	☐ Yes	☐ No	
5. Professional Board Disciplinary Action?	☐ Yes	☐ No	
6. Program Exclusion?	☐ Yes	☐ No	
7. Suspension of Payments?	☐ Yes	☐ No	
8. Civil Monetary Penalty?	☐ Yes	☐ No	
9. Assessment?	☐ Yes	☐ No	
10. Program Debarment?	☐ Yes	☐ No	
11. Criminal Fine?	☐ Yes	☐ No	
12. Restitution Order?	☐ Yes	☐ No	
13. Pending Civil Judgment?	☐ Yes	☐ No	
14. Pending Criminal Judgment?	☐ Yes	☐ No	
15. Judgment Pending under the False Claims Act?	☐ Yes	☐ No	

REGISTER FOR WEB ACCESS

Providers must identify an individual employee as the Organization Administrator (Org Admin). The Org Admin is in charge of maintaining the User ID's and login accounts to access the North Dakota MMIS Portal. An Org Admin has the ability to reset AVR PINs and Web Portal passwords, and to add and maintain users for their organization. This maintenance includes updating a user's account profile, resetting a user's password, unlocking a locked User ID, and deactivating User IDs, if needed.

Applicants with more than one service location must register for web access for each service location. The primary location's web access cannot be shared with the additional service locations. It is recommended that applicants identify a different Org Admin for each service location.

The following fields MUST be completed:

1) Organization Name
2) Organization Description
3) User ID: This is a unique ID your Org Admin will use. The User ID should consist of the first initial of the first name entered, followed immediately by the entire last name entered (no spaces or punctuation). If this User ID is already in use, the system will suggest alternate IDs to use.

NOTE: User ID can contain between 6-16 alphanumeric characters, no spaces, no special characters, and is case sensitive.

4) Last Name/First Name of the Org Admin
5) Telephone Number of Org Admin

Organization Name		Organization Description	User ID	
Prefix	Last Name	First Name	MI	Suffix
Telephone Number	Extension	Email Address		

Commercial transportation providers attest for all of their drivers and individually enrolled transportation providers attest for themselves that: They are not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services; (B) Each such individual driver has a valid drivers license; (C) Each such provider has in place a process to address any violation of a state drug law; and (D) Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

I, the undersigned commercial business owner or independent driver, affirm that the vehicle used to provide transportation is in good operating order, including the brakes, lights, and tires. I attest that I have the necessary vehicle insurance that covers transporting passengers for payment. 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.

Applicant signature is required to complete the application process.

Signature	Date

Submit by securemail, fax, or mail to:

Fax: Providers may fax the required documentation and this form to 701-433-5956 ATTN: NDM Provider Enrollment.

Email: **NDMedicaidEnrollment@Noridian.com** (please do not send EFT information, dates of birth, or Social Security numbers by unsecured email)

Mailing Address:

Noridian Healthcare Solutions
ATTN: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58121-6055