GROUP PROVIDER ENROLLMENT APPLICATION

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1601 (4-2013)

Clear Fields

This application is for a group or a sole proprietorship with an Employer Identification Number (EIN). If you are an individual or a sole proprietorship that does not have an Employer Identification Number, then you must complete the Individual Enrollment Application form.

IDENTIFYING INFORMATION

Group Information

Group Organization Name	Years Doing Business under this name
Have you ever used a different Doing Business As (DBA) name? ☐ Yes ☐ No	Former DBA Name

IMPORTANT: Your EIN will be linked to your North Dakota provider number. All claims paid to your ND provider number will be submitted as income under your EIN to the Internal Revenue Service (IRS). The EIN must be for the group whose information was given.
NOTE: If the EIN ever changes, you must reapply for a ND provider number.

Is this application due to a change of ownership (CHOW)? ☐ Yes ☐ No	Enter the previous owners provider number here

Tax Reporting Information

Legal Name	EIN	Begin Date	End Date

Current/Previous ND Provider Number

Please enter your current and/or previous provider number

Non-Profit Organization - Tax Exempt Status

Is this business listed under tax exempt status? ☐ Yes ☐ No	**Please send a copy of your IRS issued exemption**

SERVICE LOCATION, BILLING, AND MAILING INFORMATION

Service Location Information

Physical Address(PO Box Not Accepted)		
Building, Suite Number, etc.	County	
City	State	ZIP Code
Telephone Number (include area code and extension)	Fax Number	

Service Location Contact Person

Last Name, First Name, MI	Telephone Number (include area code and extension)
Position	Fax Number
E-mail	

Clear Fields

Billing Address (This address is equivalent to your Pay To address where your checks will be mailed.)

Is this address the same as the Service Location? ☐ Yes ☐ No **If yes,** skip to the next question; if no, please fill out the billing address information.

Is this address the same as the Mailing Address? ☐ Yes ☐ No **If yes,** skip to the next question; if no, please fill out the billing address information.

Payee Name	PO Box / Street Address		
Building, Suite Number, etc.		Telephone Number	
City	State	Zip Code	County

Billing Location Contact Person

Last Name, First Name, MI		Telephone Number and Extension
Position	E-mail	Fax Number

Mailing Address (This is the address where bulletins, manuals, reports, updates, etc. will be sent)

Is this mailing address the same as service location? ☐ Yes ☐ No **If yes,** skip to the next question.

PO Box / Street Address		Fax Number	
Building, Suite Number, etc.		Telephone Number	
City	State	Zip Code	County

Mailing Location Contact Person

Last Name, First Name, MI		Telephone Number and Extension
Position	E-mail	Fax Number

LICENSURE / CERTIFICATION

ATTENTION: Refer to the back of the enrollment application for a complete list of valid provider type and specialty code combinations.

NOTE: Enter information pertaining to your current licensure and/or certification. The license must be for the state in which services are rendered.

License Information

Provider Type	License Number	Licensing Agency	Effective Date	Expiration Date	State
A					
B					
C					
D					

Clear Fields

Certification Information

Provider Type	Certification Number	Certifying Agency	Effective Date	Expiration Date	State
A					
B					
C					
D					

Specialty Information

NOTE: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility.

Specialty	Provider Type	Certification Number	State	Board Name	Effective Date	Expiration Date
A						
B						
C						
D						

Taxonomy

Taxonomy Code	Effective Date	Expiration Date

PROVIDER IDENTIFIER NUMBERS

National Provider Identifier (NPI) Number List any NPI Numbers assigned to this applicant	**Drug Enforcement Agency (DEA) Number** List any DEA Numbers assigned to this applicant	**National Council for Prescription Drug Programs (NCPDP) Number** List any NCPDP Numbers assigned to this applicant
A		
B		
C		
D		

Are you or have you been previously enrolled as a Medicaid provider in another state? ☐ Yes ☐ No State

Clear Fields

GROUP AFFILIATIONS

IMPORTANT: List all active, individual North Dakota Medicaid providers who perform services on behalf of this group. This information will be cross referenced to the affiliations identified by the individual providers to ensure consistency and also to assist in claims processing.

Name Of Individual Practitioner	ND Provider Number	Effective Date Of Affiliation

FACILITY DATA

Administrator Name		
Facility Type	Begin Date	End Date

Bed Capacity

Bed Type	Total Number of Beds	Begin Date	End Date

PHARMACY

Pharmacy Type

Does this pharmacy have drive-thru accessibility? ☐ Yes ☐ No

Does this pharmacy provide delivery service? ☐ Yes ☐ No

SERVICE

Does this location provide after-hours services? **If yes**, enter number. ☐ Yes ☐ No

After-Hours Contact Telephone Number:

Provider Website

Gender Served ☐ Male ☐ Female ☐ Both

Age Range Served ☐ All ☐ 0-5 years ☐ 6-12 years ☐ 13-17 years ☐ 18-21 years ☐ 22-59 years ☐ 60+ years

Languages Supported (Check all that may apply)

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

Clear Fields

Is this location wheelchair accessible? ☐ Yes ☐ No

Are you a 340b Provider? ☐ Yes ☐ No

Do you wish to be excluded from public Provider searches? ☐ Yes ☐ No

Please define your service area by counties served, or by distance from your location:

☐ Adam	☐ 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

Hours of Operation (Enter Opening/Closing times for each day of the week that you are open.)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Interpretive Services Available (Check all that your location is equipped to serve)

☐ Braille ☐ Oral ☐ Sign ☐ TDD-TTY # _____ Other: _____

Special Needs

Check all that your location is equipped to serve

☐ Mental Health Disabilities	☐ Behaviorally Disruptive Disabilities	☐ Sexually Aggressive Disabilities
☐ Substance Abuse Disabilities	☐ Deaf/Hearing Impaired Disabilities	☐ Blind/Visually Impaired Disabilities
☐ Development Disabilities	☐ Physical Handicapped Disabilities	☐ Other Disabilities

ELECTRONIC FUNDS TRANSFER

Do you wish to participate in Electronic Funds Transfer Payments? ☐ Yes ☐ No

If yes, please fill out the EFT information below; if no, your check will be mailed to the billing address listed.

Bank Name	Bank Telephone Number	
Address		
City	State	Zip Code
Bank Routing Transit Number	Bank Account Number	Account Type ☐ Checking ☐ Savings
Account Holders Name	Payee Provider's Name	

Please submit a voided check or documentation from your financial institution.

Clear Fields

CLINICAL LABORATORY IMPROVEMENTS AMENDMENT (CLIA)

A current CLIA certificate is required when a hospital, independent laboratory, or physician's office which performs non-waivered laboratory service under CLIA is enrolling. Please include copies of all CLIA certifications that cover all dates of enrollment requested.

CLIA Number	Effective Date	Expiration Date

REMITTANCE ADVICE

Requested Delivery Media for Remittance Advices (RAs) - Choose one

- ☐ Electronic (835)
- ☐ Web Portal Inbox (Online-downloadable)
- ☐ Paper - if you have chosen a paper RA, it will be sent to the billing address listed above

Choose one of the following options, if you would like to include your suspended claims on your Remittance Advice:

- ☐ Print all suspended claims
- ☐ Do not print suspended claims
- ☐ Print only new suspended claims

RA Sort Indicator (Indicates how your remittance advice will be sorted). Choose only one.

- ☐ Transaction Control Number (TCN)
- ☐ Prescription Number
- ☐ County Code
- ☐ Claim Status
- ☐ Network
- ☐ Provider Number
- ☐ Date of Service
- ☐ Member ID
- ☐ Medical Record Number
- ☐ Member Name
- ☐ Provider Name
- ☐ Service Location

Bulletin Medium - How would you like to receive your bulletins?

- ☐ Paper
- ☐ Inbox (web portal)

ELECTRONIC TRANSACTION SUBMISSION

Indicate which of the following will be used to submit claims electronically:

☐ **North Dakota MMIS Web Portal**

Claims can be entered directly into the ND MMIS Web Portal. The Web Portal will perform basic data checks before the claim is submitted for processing, thus reducing the number for denied claims and decreasing the turnaround time for claims processing. Submitting claims electronically though the ND MMIS Web Portal is a great option for providers who currently submit paper claims.

☐ **Vendor Software**

A provider who uses Vendor Software to submit or receive transactions in X12N format is considered their own Trading Partner. A provider may elect this option as part of the electronic enrollment application. Providers who are their own Trading Partner will be contacted by a DHS representative regarding testing of transactions. Testing will need to be successful before Trading Partners will be able to submit and receive electronic transactions.

Vendor Name	Software Name	Version Number	Protocol

☐ **Billing Agent/Clearinghouse**

Providers who utilize the services of a Billing Agent or Clearinghouse to submit or receive electronic transactions, will indicate the contact name, address, and telephone information for the Billing Agent/ Clearinghouse. Providers should encourage their Billing Agent to complete the Trading Partner Enrollment application as soon as possible.

Agent/Clearinghouse Name	Contact Name

Street Address	City	State	ZIP Code	Contact Telephone Number

Please check transactions that you submit and/or receive:

Submit:

- ☐ 270 Eligibility Request
- ☐ 271 TPL Coverage Response
- ☐ 276 Claims Inquiry Request
- ☐ 278 Service Authorization Request
- ☐ 834 Benefit Enrollment & Maintenance
- ☐ 835 Remittance Advice
- ☐ 835 TPL
- ☐ 837D Dental Claim
- ☐ 837P Professional Claim
- ☐ 837I Institutional Claim

Receive:

- ☐ 270 TPL Coverage Inquiry
- ☐ 271 Eligibility Response
- ☐ 277 Claim Inquiry Response
- ☐ 278 Service Authorization Response
- ☐ 820 Premium Payment
- ☐ 824 Exception Reporting
- ☐ 834 Managed Care Enrollment
- ☐ 835 Remittance Advice
- ☐ 835 TPL
- ☐ 837I - TPL Pay & Chase
- ☐ 837P TPL Pay & Chase

Clear Fields

COORDINATION OF BENEFITS AGREEMENT (COBA)

IMPORTANT: Coordination of Benefits Agreement (COBA) claims, prior to NPI assignments, will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). COBA claims will pay to the provider number to which the Medicare number is linked.

Medicare may have issued a Medicare provider number for each facility where you provide services. Numbers assigned to you on behalf of an affiliated group should be listed in the Medicare section titled **"Medicare Numbers"** below.

NOTE: For help determining if your Medicare number is your individual number or is affiliated with a group, please contact your Medicare intermediary.

Medicare Number	Please check all that apply:	Begin Date	End Date
	☐ All ☐ Part A ☐ Part B ☐ Part C ☐ Part D		
	☐ All ☐ Part A ☐ Part B ☐ Part C ☐ Part D		

MEDICARE HISTORY

For historical purposes, please list any Medicare Provider number(s) and Carrier/Intermediary number(s)

Medicare Number	Carrier/Intermediary Name	Please check all that apply:	Begin Date	End Date
		☐ All ☐ Part A ☐ Part B ☐ Part C ☐ Part D		
		☐ All ☐ Part A ☐ Part B ☐ Part C ☐ Part D		

EXCLUSION/SANCTION INFORMATION:

1. Are any of the named owners related to the owners of the subcontractor as a spouse, parent, child, sibling or a household member?

☐ Yes ☐ No **If yes,** please provide information below.

Last name, First Name, MI	Relationship

2. Is the group chain affiliated?

☐ Yes ☐ No **If yes,** please provide information below.

Business Name	EIN	Telephone Number

Address	City, State, ZIP Code

3. Is the group operated by a management company or leased in whole or part by another organization? ☐ Yes ☐ No

4. Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5% or more in the group that have been convicted of a criminal offense related to involvement of such individuals, or organization in any of the programs established by Medicare, Medicaid and State Health Insurance Program? ☐ Yes ☐ No

5. Are there any directors, officers, agents, or managing employees of the group that have ever been convicted of a criminal offense related to their involvement in such programs established by Medicare, Medicaid and State Health Insurance Program? ☐ Yes ☐ No

6. Has any family or household member or any person who has ownership or controlling interest in the group, ever been convicted, assessed, or excluded from State or Federal programs due to fraud, obstruction of an investigation or a controlled substance violation? ☐ Yes ☐ No

Last Name, First Name, MI	Relationship

7. Does the applicant under any name or business identity, have any outstanding overpayments with any state or federal program? ☐ Yes ☐ No

Last Name, First Name, MI	Federal Program Name

Clear Fields

8. Has the applicant ever been convicted of a felony under Federal or State Law? ☐ Yes ☐ No **If yes**, please add appropriate documentation pertaining to the situation.	Date of Occurrence

If you have ever had any of the following adverse legal actions imposed or pending by any federal 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).

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

OWNERSHIP INFORMATION:

1. How many owners of this application have a 5% or more ownership interest in the group?
(Attach separate document, if necessary)

If the owner is an individual, complete this area.

Last name, First Name, MI			Title
Doing Business as (DBA) Name			Effective Date of Ownership
Date of Birth	Country/State of Birth	SSN	ND Provider ID

If the owner is a group, complete this area.

Business Name		ND Provider ID
Doing Business as (DBA) Name	EIN	Effective Date of Ownership

2. Are any of the persons with an ownership or controlling interest in the provider's company related to one another as spouse, parent, child, sibling or household member?
☐ Yes ☐ No **If no,** skip to next question.

Last Name, First Name, MI	Relationship	Date of Birth	Social Security Number

Clear Fields

3. What is the total number of managing/directing employees for the group?
Attach separate document, if necessary. _____

Last Name, First Name, MI		Title
Date of Birth	Country/State of Birth	Social Security Number

4. Has this managing/directing employee ever had a Medicaid Provider number in this or any other state?

☐ Yes ☐ No **If yes,** please enter information below. Attach separate document, if necessary.

Business Name			Employee Name	
Social Security Number	Date of Birth		Effective Date	End Date
Social Security Number/EIN	Current Provider Number	State	Prior Medicaid Provider Number	State

5. Do any of the members of your immediate family (spouse, parent, child, sibling) have ownership of 5% or greater in a subcontractor to your business or practice? (A subcontractor is an individual, agency, or organization to which an applicant/provider has contracted responsibilities of providing medical care to its patients.)

☐ Yes ☐ No Please complete the following for each additional owner.

Last Name, First Name, MI	Relationship	Date of Birth	Social Security Number
Subcontractor Name	Address	City, State, Zip	

Authorized Representative

Last Name, First Name, MI, Suffix, Title		Date of Birth
Position	Begin Date	End Date

Pharmacist in Charge

Last Name, First Name, MI, Suffix, Title

NON-MEDICAL PROVIDERS (MEALS, TRANSPORTAION, LODGING)

List your Medicaid eligible recipients.

Member's Medicaid ID Number	Last Name, First Name, MI	
Is this Member a Foster Child or Adult? ☐ Yes ☐ No	Does the member reside in the same household? ☐ Yes ☐ No	**If yes,** explain

What is your relationship to the person to whom you are providing services?

☐ Spouse ☐ Father/Mother ☐ Child ☐ Brother/Sister ☐ Other _____

All Transportation Providers: You are required to submit, with your application, a copy of your current valid driver's license and proof of insurance.

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) Contact Name and telephone number: this is the name of your Org Admin.

Organization Name			Organization Description	User ID	
Prefix	Last Name		First Name	MI	Suffix
Telephone Number		Extension	E-mail		

SIGNATURE

Signature	Title	Date

PROVIDER TYPE CODE-*Description*
PROVIDER SPECIALTY CODE-Description

TYPE 017 - Other Service Providers

335-Case Manager/Care Coordinator
468-County Social Service Office
339-Lodging
393-Provide Meals

TYPE 025 - Agencies

035-Case Management
357-Community/Behavioral Health
060-Early Intervention; Provider Agency
082-Home Health Agency
454-Hospice Care, Community Based
453-Human Service Center
397-Local Education Agency (LEA/Special
358-PACE
261-Public Health or Welfare

TYPE 026 - Ambulatory Health Care Facilities

026-Adolescent and Children Mental Health
070-Adult Mental Health
089-Ambulatory Surgical Center
071-Augmentative Communication
359-Clinic/Center
040-Community Health Centers
437-Dental Clinic
271-Emergency Care
300-End-Stage Renal Disease (ESRD) Treatment
299-Endoscopy
015-Family Planning Non-Surgical
361-Federally Qualified Health Center
332-Hearing & Speech
186-Infusion Therapy
395-Magnetic Resonance Imaging (MRI)
360-Mental Health (Including Community Mental Health)
406-Migrant Health
408-Occupational Medicine
107-Oncology
409-Oncology, Radiation
410-Ophthalmologic Surgery
212-Oral Maxillofacial Surgery
218-Pain Management
110-Physical Therapy
048-Podiatric
413-Primary Care
416-Public Health, State or Local
030-Radiology
417-Radiology, Mammography
418-Radiology, Mobile
419-Radiology, Mobile Mammography
420-Rehabilitation
422-Rehabilitation, Comprehensive
364-Rehabilitation, Substance Use Disorder Unit
423-Rehabilitation, Cardiac Facilities
268-Rural Health Clinic
424-Sleep Disorder Diagnostic
426-Student Health
288-Urgent Care Center

TYPE 027 - Hospital Units

362-Psychiatric Unit; Hospital Unit
363-Rehabilitation Unit; Hospital Unit
364-Rehabilitation, Substance Use Disorder Unit
196-Swingbed (Medicare Defined)

TYPE 028 - Hospital

156-Chronic Disease Hospital
111-Critical Access: Hospital
091-General Acute Care Hospital
192-Long Term Care Hospital
131-Psychiatric Hospital
421-Rehabilitation Hospital

TYPE 029 - Laboratories

054-Clinical Medical Lab
366-Physiological Lab (Independent Physiological Lab)

TYPE 030 - Managed Care Organizations

367-Health Maintenance Organization

TYPE 031 - Nursing & Custodial Care Facilities

371-Alzheimer/Dementia/Dementia Special Care
440-Basic Care in a Nursing Facility
370-Custodial Care Facility
438-Gero Psych Nursing Home
181-Hospice, Inpatient
369-Intermediate Care Facility-Mental Illness
439-Non Gero Psych Nursing Home
269-Skilled Nursing Facility
450-Skilled Nursing Facility-Institutes for Mental Disorders (IMD)

TYPE 032 - Residential Treatment Facilities

258-Psychiatric Residential Treatment Facility (PRTF)
451-Psychiatric Residential Treatment Facility-Institutes for Mental Disorders
264-Residential Treatment Facility (RTF), Emotionally Disturbed Children
265-Residential Treatment Facility (RTF), Mental Retardation and/or DD
266-Residential Treatment Facility (RTF), Physical Disabilities
274-Substance Abuse Disorder Treatment Facility
427-Substance Abuse Treatment, Children

TYPE 033 - Suppliers

472- Clinic Pharmacy
473-Community/Retail Pharmacy
474-Compounding Pharmacy
113-Durable Medical Equipment & Medical Suppliers
384-Eyewear Supplier
383-Hearing Aid Equipment
475-Home Infusion Therapy Pharmacy
486-Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy
476-Institutional Pharmacy
477-Long Term Care Pharmacy
478-Managed Care Organization Pharmacy
480-Non-Pharmacy Dispensing Site
481-Nuclear Pharmacy
128-Pharmacy
116-Portable X-Ray Supplier
347-Prosthetic/Orthotic Supplier
428-Specialty Pharmacy

TYPE 034 - Transportation Services

483-Air Carrier
132-Ambulance
385-Bus
387-Private Vehicle
388-Secured Medical Transport (Van)
389-Taxi
390-Train
484-Transportation Broker

TYPE 039 - Developmental Disabilities

335-Case Manager/Care Coordinator
380-Congregate Care (DD)
374-Day Support (DD)
373-Extended Services (DD)
379-Family Support Services (DD)
377-Independant Supported Living Arrangement (DD)
372-Infant Development (DD)
354-Intermediate Care Facility (ICF/MR)-(DD)
381-Minimally Supervised Living Arrangement (DD)
382-Supported Living Arrangement (DD)
376-Transitional Community Living Facility (DD)

TYPE 043 - Basic Care

079-Basic Care Facility
452-Basic Care-Institute for Mental Disorders IMD
370-Custodial Care Facility

TYPE 047 - Indian Health Services

132-Ambulance
359-Clinic/Center
300-End Stage Renal Disease (ESRD) Treatment
091-General Acute Care Hospital