REQUEST TO ADD AN AFFILIATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION/ PROVIDER ENROLLMENT
SFN 1330 (10-2018)

The Department will not gran[t] than one year from the date of receipt. Credentialing staff must ensure the effective date is c[orrect] ffiliation paperwork. Any [change] ange the date will not be considered.

Name of Individual Practitioner being Affiliated

Date the Form is submitted to the Department

Name of Provider	Date	
NPI — NPI of Individual being Affiliated	Health Enterprise Number — 7 Digit Medicaid ID of the Individual Practitioner being Affiliated	
Service Location Ad[dress] — Address where the Individual is providing services. if more than one service location, please submit a list of all service locations.	City	State / ZIP Code
Is this the primary s[ervice location]? ☐ Yes ☐ No	Requested Effective Date — The Department will not grant an effective date that is more than 90 days from the date the affiliation request (correct and complete with all attachments) is received.	

Please submit a list of all service location addresses being added for this individual at the time of this request a[ffiliation].
These service locations must already be added to the Medicaid provider number of the billing provider listed be[low].

AFFILIATE TO

Name of Billing Group (Facility billing for the practitioner's services)

Billing Provider Name	Billing Provider Health Enterprise Number — 7 Digit Medicaid ID of Billing Group (Facility) REQUIRED	
Billing Address — Billing and Mailing Addresses of the Billing Group	City	[State] / ZIP Code
Mailing Address	City	State / ZIP Code

Please submit the following documentation with this request:

1. Copy of current license. North Dakota Medicaid requires providers to be licensed in the state where the provider is rendering services.
2. Copy of current DEA license (if applicable).

If these items are not received, your affiliation request is **not complete**

Submit by fax, email or mail to:

Fax: Providers may fax the required documentation and this form to 701-328-4030.

Email: dhsenrollment@nd.gov

Mailing Address:

Provider Enrollment
Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave. Dept. 325
Bismarck, ND 58505-0250

Name, Phone, and Email are all Required Fields

CONTACT INFORMATION FOR REQUESTOR

Name, phone, and email of person filling out this form - usually credentialing staff.

Name	Telephone Number
Email Address	