

9. What is the service location name, address, and phone number?

Name: _____

Address: _____

City-State-Zip & Zip Plus 4: _____

Phone Number: _____

Fax Number: _____

Contact Person: _____ E-mail _____

10. What is the address where remittance notice {EOB} will be sent)?

Name: _____

Address: _____

City-State-Zip Zip Plus 4: _____

Phone Number: _____

Fax Number: _____

Contact Person: _____ E-mail _____

11. When does billing location fiscal year end? _____

The 'Authorized Signature' on the provider agreement must be the Director, Administrator, CEO or CFO. A stamped signature or office manager's signature is not acceptable. An original signature is required.

Please ensure the following are enclosed before mailing:

- Completed Diabetes Enrollment Application.
- Completed Provider Agreement.
- **American Diabetes Association Certificate or South Dakota Department of Health Recognition Letter** (required)
- Copy of original licensure showing expiration date.
- Completed W9.
- Completed Direct Deposit Agreement along with voided check, voided deposit slip or letter from bank indicating correct routing number and checking account number.
- Completed Ownership and Conviction Disclosure.
- Please include Zip Plus 4 on the service and pay to address above.

Please return the completed forms along with requested information/documentation to:

Provider Enrollment
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Upon receipt of all necessary information, a determination will be made regarding your qualifications as a provider under the South Dakota Medical Assistance Program. When a determination has been made, notification will be sent along with a copy of the approved provider agreement for your files.