NORTH DAKOTA COLORECTAL CANCER SCREENING INITIATIVE (INITIATIVE)
APPLICATION FOR PROVIDER COOPERATIVE AGREEMENT

NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY AND HEALTH SYSTEMS
11-2022

Section I: Organization Information

Organization Name		Tax ID Number	
Street Address	City	State	Zip
Mailing Address (if different)	City	State	Zip
Organization Contact Name (Admin)	Contact Phone	Contact Email	
Clinic Contact Name	Contact Phone	Contact Email	

Section I-1: Intent to Provide Services for the Initiative

Identify **only** the services, providers, and tests intended to be associated with the North Dakota Colorectal Cancer Screening Initiative.

Services
(check all that apply)
- ☐ Clinic
- ☐ Laboratory
- ☐ Radiology
- ☐ Pharmacy
- ☐ Other (specify)
- ☐ Hospital
- ☐ Pathology Laboratory
- ☐ Outpatient Surgery
- ☐ Anesthesia

Providers
(check all that apply)
- ☐ Physician
- ☐ Physician Assistant
- ☐ Pharmacist
- ☐ Anesthetist
- ☐ Other (specify)
- ☐ Nurse Practitioner
- ☐ Radiologist
- ☐ Anesthesiologist

Our facility provides the following colorectal cancer screening tests:
(check all that apply)
- ☐ iFOBT or FIT Stool Test
- ☐ Multi-targeted Stool DNA Test (Mt-sDNA) such as Cologuard®
- ☐ Colonoscopy

Services Associated with Colonoscopy:
(check all that apply)
- ☐ Laboratory Services
- ☐ Histology Services
- ☐ Providers to Perform Anesthesia Services
- ☐ Providers to Perform Endoscopic Procedures
- ☐ Other Services Associated with Colonoscopy (specify)

Section II: Laboratory Services

- ☐ Our facility has a laboratory or has a contract with another laboratory. (Complete this section)
- ☐ Our facility **does not** utilize laboratory services as part of our service for colorectal cancer screening. (Skip to Section III)

Laboratory Facility Name	Accreditation Verified ☐ Yes ☐ No	CLIA Number	
	Is this laboratory on site? ☐ Yes ☐ No	CLIA Effective Date	
Laboratory Contact Name		Contact Phone	
Laboratory Address (if different)	City	State	Zip

By signing below, your organization verifies that the named laboratory meets the standard for and is certified as a Clinical Laboratory Improvement Amendments (CLIA) laboratory.

Signature of Health Care Facility Representative	Date

Please submit your completed application electronically to ndcrc@qualityhealthnd.org

Section III: Histology Laboratory Services

☐ Our facility has a histology laboratory or has a contract with another histology laboratory. (Complete this section)
☐ Our facility **does not** utilize histology laboratory services as part of our service for colorectal cancer screening. (Skip to Section IV)

Histology Laboratory Facility Name		Accreditation Verified ☐ Yes ☐ No		Certification Number
Certifying Organization Name		Is this laboratory on site? ☐ Yes ☐ No		Certification Effective Date
Histology Laboratory Contact Name				Contact Phone
Histology Laboratory Address (if different)	City		State	Zip

By signing below, your organization verifies that the named laboratory will report pathology findings for Initiative clients using industry standards.

Signature of Health Care Facility Representative	Date

Section IV: Providers for Anesthesia Related to Endoscopic Services

☐ Our facility employs on-site providers for anesthesia services. (List Anesthesia providers in Section VII: Provider Information; skip to Section V)
☐ Our facility contracts with providers for anesthesia services. (Complete this section)
☐ Anesthesia services are not available at our facility. (Skip to Section V)

Anesthesia Facility or Provider Name	Anesthesia Contact Name		Contact Phone
Anesthesia Facility Address (if different)	City	State	Zip

List all Anesthesia providers in Section VII: Provider Information.

Section V: Providers for Endoscopic Services

☐ Our facility employs on-site providers for endoscopic services. (List endoscopy providers in Section VII: Provider Information; skip to Section VI)
☐ Our facility contracts with providers for endoscopic services. (Complete this section)
☐ Our facility refers patients to another facility for endoscopic services. (Complete this section)

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address (if different)	City	State	Zip

Use Section VIII: Additional Providers for Endoscopic Services to list additional referral facilities.
List all providers for endoscopic services in Section VII: Provider Information.

Section VI: Other Services Related to Colorectal Cancer Screening Not Previously Included in This Application

☐ Our facility provides other services that may be related to Colorectal Cancer Screening. (Complete this section)
☐ Our facility does not provide other related services. (Skip to Section VII)

Other services provided:

☐ Annual Physicals / Annual Wellness Visits
☐ Prevention Appointments
☐ Pre-op Exams
☐ Patient Education
☐ Patient Navigation
☐ Other (please describe)

Please submit your completed application electronically to ndcrc@qualityhealthnd.org

Section VII: Provider Information

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Last Name		First Name
NPI	TIN (if different than organization)	Credential(s)
Role(s) ☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)		

Please submit your completed application electronically to ndcrc@qualityhealthnd.org

Section VII: Provider Information (continued)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Last Name		First Name
NPI	**TIN** (if different than organization)	**Credential(s)**

Role(s)
☐ Ordering Provider ☐ Endoscopy Provider ☐ Anesthetist ☐ Anesthesiologist ☐ Pharmacist ☐ Other (specify)

Please submit your completed application electronically to ndcrc@qualityhealthnd.org

Section VIII: Additional Providers for Endoscopic Services

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Facility Providing Endoscopic Services	Endoscopy Contact Name		Contact Phone
Endoscopy Facility Address	City	State	Zip

Please submit your completed application electronically to ndcrc@qualityhealthnd.org