

# NCMMIS Human Service Organization Enrollment Participant User Guide

#### **PREPARED FOR:**

North Carolina Department of Health and Human Services

DHHS MES VMU

#### **TRACKING NUMBER:**

PUG\_HSO002 Version D1.0.1 **REVIEW/ACCEPT** 

#### **SUBMITTED BY:**

CSRA A General Dynamics Information Technology Inc. company





NC DEPARTMENT OF HEALTH AND HUMAN SERVICES November 22, 2021

ATTENTION - THIS TRAINING IS INTENDED FOR COVERED ENTITIES AND BUSINESS ASSOCIATES WHO ARE CONSIDERED TO BE STAKEHOLDERS OF THE NCTRACKS APPLICATION.





# **Document Revision History**

Version	Date	Description of Changes
D1.0.1	November 22, 2021	Initial submission





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# 1.0 Welcome

#### **1.1 COURSE OVERVIEW**

Welcome to this course on Human Service Organization Provider Enrollment (HSO). This course will guide users through the process of completing a Human Service Organization Provider initial enrollment application in the NCTracks Provider Portal.

#### **1.2 COURSE BENEFITS**

This course will guide users through an overview of the initial Enrollment process for Human Service Organization Providers.

#### **1.3 COURSE OBJECTIVES**

At the end of this training, users will be able to understand the Provider Enrollment Application process, navigate to the NCTracks Provider Portal, and complete the following Provider Enrollment Application processes.

#### **1.4 PREREQUISITES**

None.

#### NOTES:





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# 2.0 Human Services Organization Applications

### 2.1 INTRODUCTION

This course will guide users through the process of completing a Human Service Organization Provider enrollment application in the NCTracks Provider Portal.

- <u>Initial Enrollment</u> You will complete an initial Enrollment application if you want to newly enroll with NC DHHS.
- <u>Re-verification</u> Most providers are required to provide a Re-verification application every 5 years; however, atypical providers with HSO-only taxonomy codes are exempt from Re-verification.
- <u>Maintain Eligibility</u> If you have not had any claim activity within the last 12 months, you are required to complete a Maintain Eligibility application if you intend to stay active.

#### 2.2 OBJECTIVES

Trainees will view demonstrations of completing the above applications. This Participant User Guide will also provide step-by-step documentation of the processes to complete and submit applications.

A majority of the demonstration sections will have graphic illustrations followed by numbered **steps**. The numbers on the images will correspond with the numbers in the **steps**.

#### 2.3 HELP SYSTEM

The major forms of help in the NCTracks system are as follows (refer to Addendum A):

- Navigational breadcrumbs
- System-Level Help Indicated by the "NCTracks Help" link on each screen
- Screen-Level Help Indicated by the "Help" link above the Legend
- Legend
- Data/Section Group Help Indicated by a question mark (?)
- Hover-over or Tooltip Help on form elements



North Carolina Medicaid Management Information System (NCMMIS)



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# **3.0 Initial Enrollment**

#### 3.1 NAVIGATING TO PROVIDER APPLICATIONS – INITIAL ENROLLMENT

You will navigate to Provider Applications via the NCTracks Provider Portal.



**Exhibit 1. NCTracks Home Page** 

Step	Action
1	Select the <b>Providers</b> link. The public <b>Providers</b> page displays.





Home <u>Providers</u> Rec	pients Operations			
Home  Providers Provider Enrollment				
Getting Started With NCTracks	Provider Enrollment		Fingerprinting	
Provider Communication Frequently Asked Questions	recognizes the need to promote	CATION TYPE	This page includes a list of answers to frequently asked	
Currently Enrolled Provider (CEP) Registration	access to care by Individual enrolling all	a person enrolled directly who may it comoleting the Individual Provider Er	questions (FAQs) and other resources regarding provider fingerprint-based criminal	
Claims	providers in a savces, When you are savces, When you are finance of the savces of the	(P) in the CCNC/CA program if your	background checks. read on ()	
Prior Approval	timely manner		Contact	
Provider Enrollment	for our citizens		CSRA Call Center	
2 Getting Started With Enrollment			Provider Enrollment 2610 Wycliff Road, Suite 100	
Supporting Information	ion       The enrollment process includes credentialing, endorsement, and licensure verification. The CSRA Enrollment Team completes this verification to ensure that all providers meet the professional requirements and are in good standing. Once participation as a DHHS provider has been approved, providers are notified by email NCTracksprovid       Raleigh, NC 276         Search       Work       800-4         Fax       855-7         Prequirements and are in good standing. Once participation as a DHHS provider has been approved, providers are notified by email       NCTracksprovid		Raleigh, NC 27607 Work 800-688-6696	
Terms and Conditions			Fax 855-710-1965	
Enrolled Practitioner Search			E-Mail <u>NCTracksprovider@nctracks.c</u>	
ICD-10	The CSRA Enrollment Team cannot prov	ide special consideration for		
Provider Re-credentialing/Re- verification	processing of enrollment applications due to provide special consideration for incomplete information, or due to a delay in obtaining credentialing, endorsement or licensure information from another agency.		Quick Links	
Provider Policies, Manuals, Guidelines and Forms			<u>Re-verification Refresher</u> (PDF, 1767 KB)	
Provider User Guides and Training	Applicants must meet all program requir for which they are seeking enrollment b as DHHS providers. Specific qualification	effore they can be enrolled is for each provider type	Provider Enrollment Frequently Asked Questions (FAOs)	

#### Exhibit 2. Public Providers Page

Step	Action
1	Select Provider Enrollment; menu options display.
2	Select the Getting Started With Enrollment menu option. The Getting Started page displays.





Home <u>Providers</u> F	Recipients Operations	
Home  Providers  Provider Enrollm	sent • Getting Started With Enrollment	
Getting Started With NCTrack Provider Communication Frequently Asked Questions Currently Enrolled Provider (CEP) Registration	<b>Getting Started With Enrollment</b> The Provider Enrollment Online Application is a user- friendly web application that gathers all the information needed to enroll you or your organization as a licensed Medicaid provider in North Carolina. The following information will help you get started with your application	Contact CSRA Call Center Provider Enrollment 2610 Wycliff Road, Suite 100 Raleigh, NC 27607 Work <b>800-688-6696</b> Fax <b>855-710-1965</b>
Prior Approval Provider Enrollment Getting Started With Enrollment	To assist you with completing an application, you will need the required information readily available. See the <u>Provider Permissi</u> <u>Matrix</u> . Providers <u>within 40 miles</u> of the border of North Carolina eligible to provide in-state Medicaid services for the State of N Carolina.	E-Mail NCTracksprovider@nctracks.co
Supporting Information Terms and Conditions Enrolled Practitioner Searc ICD-10 Provider Re-credentialing/Reverification Provider Policies, Manuals, Guidelines and Forms	Once you have completed minimal required information for your application, you will be given the opportunity to save it as draft later completion. When you are completing an Individual or Organization Provider Enrollment application, you will be given the option to also enror a Primary Care Provider (PCP) in the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) program if your provider to qualifies you to participate. See <u>CCNC/CA Eligible Provider</u> (1) You may begin your Provider Enrollment Online Application here	it for       North Carolina Border ZIP Codes         Provider Enrollment       Frequently Asked Questions (FAQs)         vpe       Provider Permission Matrix (XLSX, 811 KB)         Provider Permission Matrix Instructions (PDF, 507 KB)
Provider User Guides and Training	PDF documents on this page require the free Adobe Reader to and print.	view

Step	Action
1	Select the You may begin your Provider Enrollment Online Application here link. The NCTracks Login page displays.

NCTracks Login	AA   Help	
The NCTracks Web Portal contains information that is private and confidential. If you are not an authorized individual, this private and confidential information is not intended for you. If you are not authorized to access this content, please click 'Cancel'.		
By continuing, you are agreeing that you are authorized to access confidential eligibility, enrollment and other health insurance coverage information. Please read more in our <u>Legal</u> and <u>Privacy Policy</u> pages.		
YOUR ACCOUNT		
<ul> <li>All users are required to have an <u>NCID</u> to log in to secure areas.</li> <li>Passwords are ne-sensitive. Please ensure your Caps 2k key is off.</li> </ul>		
User ID (NCID): Password: Forgot Login Forgot Password		
3 🙆 Log In Clear Cancel		

### Exhibit 4. NCTracks Login Page

Step	Action
1	User ID (NCID): Enter your <b>NCID</b> .
	Note: It is assumed that your Office Administrator (OA) will be the person who is completing
	the application. The OA will log in with their NCID and password. If logging in as an ES, refer
	to the Participant User Guide PRV 562 Enrollment Specialist User.





Step	Action
2	Password: Enter your <b>Password</b> .
3	Select the Log In button. The Provider Portal displays.
Note	Select the <b>NCID</b> link only if provider (the OA) does not have an NCID.
	Once on the North Carolina Identity Management (NCID) website, click Register. The new User registration page will display. Select Individual. Fill out all of the required fields Desired username First Name Last Name Email Address Mobile Number (Not Required but recommended) New password Password is case sensitive. Must be at least 8 characters long. Must not include part of your name or user name. Must not include part of your name or user name. Must not include a common word or commonly used sequence of characters. Can be changed no more often then once every 3 days. Must have at least 3 of the 5 character types below: Uppercase (A-Z) Lowercase (a-z) Number (0-9) Symbol (!, #, \$, etc.) Other language characters not listed above New password may not have been used previously.
Note	Click Continue     Passwords are case-sensitive. After three unsuccessful attempts, the user will be locked out:
NOLE	however, NCTracks will provide a contact number that the user can call for access assistance. Multi-Factor Authentication (MFA) is required. After the user enters the user ID and password, the second level authentication will be sent to the user's preferred method (Phone or Mobile App). For more information on the MFA registration process, please refer to the <i>Provider Multi-Factor Authentication Registration Process</i> job aid located in SkillPort.

#### 3.2 ONLINE PROVIDER ENROLLMENT APPLICATION PAGE

On the **Online Provider Enrollment Application** page, you will enter your ZIP code for the administrative office for the HSOs Healthy Opportunities Pilots work in order for NCTracks to determine if you are an In-State, Border, or OOS provider. You will also select your **Provider Enrollment Application Type**.





Provider Portal	Eligibility Prior Approval Claims Referral Code Search Enrollment Administration Trading Partner Payment Consent Forms Training PORTAL-DEV
Home Provider Enrollment Online Provid	ier Enrollment Ap
Contact Information	Online Provider Enrollment Application
If you have any questions regarding completion of Provider Enrollment, please contact CSRA Call Center.	★ Indicates a required field
Phone: 800-688-6696 Fax: 855-710-1965	Provider Location ?
Email: NCTracksprovider@nctracks.com	Please enter the 9-digit ZIP Code (ZIP +4) of your primary practice location for determination of In-State, Border, or Out-of-State enrollment.
	1 ZIP Code: 00000-0000
Quick Links	PROVIDER ENROLLMENT APPLICATION TYPE
Status and Management	Individual
Provider Enrollment Home	An individual provider is a person enrolled directly who may have an affiliation with an organization or may bill independently for services. When you are
PE Supporting Information	completing the Individual Provider Enrollment application, you will be given the opportunity to also enroll as a Primary Care Provider (PCP) in the CCNC/CA program if your provider type qualifies you to be a PCP.
PE Terms and Conditions	Organization
Batch Enrollment Status	O An Organization is an entity, facility, or institution that may be an affiliation of individual providers. When you are completing an Organization Provider Enrollment application, you will be given the opportunity to also enroll as a PCP in the CCNC/CA program if your provider type qualifies you to be a PCP.
	Atypical Individual
	Are you an atypical individual? As defined by CMS: Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal or regulations at 45 CFR section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI.
	Atypical Organization
	Are you an atypical organization? As defined by CMS: Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal or egulations at 45 CFR section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI.
	Billing Agent
	<ul> <li>Billing Agents and Clearinghouses are third party entities—businesses—that submit information directly to CSRA as the NC DHHS Fiscal Agent on behalf of an enrolled provider.</li> </ul>
	*
	Please be sure to complete all required fields with valid content.
	About Legal Privacy Accessibility Contact Us System Regultements Report Fraud

Exhibit 5. Online Provider Enrollment Application Page

Step	Action
1	ZIP Code: Enter your <b>ZIP Code</b> .
2	Provider Enrollment Application Type: Select <b>the applicable application type.</b>





#### **3.3 ORGANIZATION BASIC INFORMATION PAGE**

The **Organization Basic Information** page captures basic information for Organization providers.

indicates a required field			Legend
DENTIFYING INFORMATION			
* Organization Name:			
* EIN:	00-000000	* NPI:	000000000
* Email:		* Month of Fiscal Year End:	Select One V
* Do you operate under a trade of	company name?		
O Yes O No			
OWNERSHIP INFORMATION			
* Business Type:	Select One	$\checkmark$	
OFFICE ADMINISTRATOR (AUTHORIZED	NDIVIDUAL)		
* User ID (NCID):	Select One V	s on benair or applying provider. This rol	e currently belongs to the person populated
* Last Name:		* First Name:	
Middle Name:		Suffix:	Select One V
	(Enter your full middle name)		ocicit one
* Contact Email:		* SSN:	
* Office Phone #:	(000) 000-0000 ext.	Office Fax #:	(000) 000-0000
□ I attest that I have entered the	full legal name of the individual, an	d the individual does not have a middle i	name.
EFFECTIVE DATE REQUESTED			
The effective date is the earliest of that a complete Provider Enrollme	ate a provider may begin billing for s nt Packet is received and may not pr	ervices. The effective date of enrollment recede, as applicable, the current date of	t may not be more than 365 days prior to the your licensure or the current date of your lett
of endorsement.	ctive date may not be retroactively n	equested.	
THE PARTY OF THE P	mm/dd/sass		
* Effective Date:			
Effective Date:     I atteat that the December 1 off	active Date is correct and under the	that it cannot be channed and the	liention is submitted
Effective Date:     I attest that the Requested Effective	ective Date is correct and understand	that it cannot be changed once the app	lication is submitted.

#### **Exhibit 6. Organization Basic Information Page**

Step	Action
1	Identifying Information: Enter Organization Name, EIN, NPI, Email, and Month of Fiscal Year End.
2	<ul> <li>Doing Business As (DBA): Answer Yes or No to the question: "Do you operate under a trade or company name?".</li> <li>If you answer Yes, the field will expand, prompting you to enter the DBA Name and Years</li> </ul>





Step	Action
	Doing Business Under This Name.
	<b>Note</b> : The DBA Name must be registered in the county where the service is being provided
	<ul> <li>If you answer No, you may continue to the next required field on the page.</li> </ul>
3	Ownership Information: Select the Business Type from the drop-down menu:
	• <b>City/Municipality:</b> Select this if the Organization is owned by a City or a Municipality.
	<ul> <li>Corporation: Select this if this is a legal entity that is separate from the people who own it.</li> <li>Shareholders govern the corporation indirectly by electing people to manage it</li> </ul>
	<ul> <li>Federal: Select this if ownership falls within the jurisdiction of the federal government.</li> </ul>
	<ul> <li>Indian Health Services: Select this if the ownership falls within the jurisdiction of the Indian Health Services</li> </ul>
	<ul> <li>Limited Liability Corporation: Select this (filing status) if this is a Limited Liability</li> <li>Corporation (LLC)</li> </ul>
	<ul> <li>Local Government Agency: Select this if the Organization is owned by a City or a</li> </ul>
	Municipality.
	Non-Profit: Select this if it is a non-profit enterprise.
	<ul> <li>Partnership: Select this if it is a General Partnership, or a Limited Partnership, where two or more people have created this business entity</li> </ul>
	<ul> <li>State: Select this if the entity is owned by the state in which it operates.</li> </ul>
Note	The Organization Name and DBA Name fields only allow the following characters:
	<ul> <li>Alpha (A – Z)</li> </ul>
	• Numeric $(0 - 9)$
	Ampersand (&)
	If Yes is selected for the question "Will your income be reported to an EIN?", enter DBA Name and Years Doing Business Under This Name
	The <b>DBA Name</b> field only allows the following characters:
	• Alpha (A – Z)
	• Numeric $(0-9)$
	Ampersand (&)
4	Office Administrator (Authorized Individual): Enter Last Name, First Name, Contact Email, Office Phone #, and User ID (NCID).
5	Effective Date Requested: Enter earliest HSO-NL contract Effective Date
6	Check box beside Attestation" I attest that the requested effective date is correct and
	understand that it cannot be changed once the application is submitted.
7	Click Next.



North Carolina Medicaid Management Information System (NCMMIS)



#### **3.4 TERMS AND CONDITIONS PAGE**

The Terms and Conditions page captures the terms and conditions to which you must agree in order to enroll in NCTracks. It also requires that you attest your agreement to the terms and conditions.

#### Terms and Conditions

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#### indicates a required field

#### NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDER ADMINISTRATIVE PARTICIPATION AGREEMENT

1. Parties to the Agreement

This Agreement is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the "Department", and the above identified provider, hereinafter referred to as the "Provider."

#### 2. Agreement Document

The Agreement Documents shall consist of this Agreement, any addendum, and the Provider's application, incorporated herein by reference. No alterations or modifications shall be made to the terms of this Agreement unless through a written amendment executed by both parties. In the event of any conflict between the terms of this Agreement and any of its addenda, the terms of this Agreement shall control.

3. Governing Law and Venue This Agreement shall be governed by the laws of the State of North Carolina, exclusive of its conflicts of laws provisions. In the event of a lawsuit involving this Agreement, venue shall be proper only in Wake County, North Carolina. This Agreement shall not be construed as wa any immunity to suit or liability including, without limitation, sovereign immunity, which may be available to the Department. construed as waiving

The Provider agrees to operate and provide services in accordance with all federal and state laws, regulations and rules, and all policies, provider manuals, implementation updates, and bulletins published by the Department, its Divisions and/or its fiscal agent in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

All provider administrative participation agreements with the Department are terminable at will. Nothing in these Regulations creates in the provider a property right or liberty right in continued participation in the Medicaid program.

#### 4. License The Provider agrees to:

- A. Be licensed, certified, registered, accredited and/or endorsed as required by State and/or Federal laws and regulations, and NC DHHS policies and procedures at all times that services are provided.
- B. Notify the Department within seven (7) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.
  C. Not bill the Department for services rendered during the lapse, for whatever reason, of any required license, certification, registration, accreditation and/or endorsement as required by State and/or Federal law or policy.

#### 5. Billing and Payment

The Provider agrees:

- A. To submit claims for services rendered to eligible recipients of the Department's medical or behavioral health care benefits, hereinafter referred to as "recipients", in accordance with rules and billing instructions in effect at the time the service is rendered. Provider agrees to be responsible for research and correction of all billing discrepancies.
- B. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered by the Department, except for payments from legally liable third parties, authorized co-payments and/or deductibles by recipients for goods, services, or supplies provided to a recipient if such are not covered by the Department.
- C. That in no event shall the Department be liable or responsible, either directly or indirectly, to any subcontractor of the provider or any other party that may provide services.
- D. To be held to all the terms of this Agreement even though a third party agent may be involved in billing claims to the Department. It is a breach of this Agreement to discount client accounts to a third party agent or to pay a third party agent a percentage of the amount collected.
- E. To investigate and bill other insurers and third parties, including the Medicare program, if applicable, before billing the Department, when the recipient is eligible for payment for health care or related services from another insurer or person.
   F. To not bill the recipient or any other person for items and services covered by Department and to refund payments made by or on behalf of the recipient for any period of time the recipient is Department approved, including dates for which the recipient is retroactively entitled to Department services.
- G. To accept assignment of Medicare payment in order to receive payment from the Department for amounts not covered by Medicare for dually eligible recipients.
- To refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the provider or the Department and/or its agents.
- I. That payment for covered services by the Department is limited to those services certified as medically necessary for the proper management, control, or treatment of recipient's medical or behavioral needs and provided under the physician's or practitioner's direction and supervision.
- That items or services provided under arrangements or contracts between the Provider and outside entities and professionals shall meet the requirements of paragraph 4.
- K. That payment and satisfaction of claims will be from federal and state funds.
- L. That claims are subject to the Medical Assistance Provider False Claims Act and the federal False Claims Act.
- A. That the Department may withhold, payments because of irregularity for whatever cause until such irregularity is resolved, or may recoup or recover overpayments, penalties or invalid payments due to error of the Provider and/or the Department and their agents. All provider numbers in which the provider has an interest are equally subject to such withholding, recoupment or recovery until such overpayment, penalty, or invalid payment is repaid to the Department. That hillings and reports related to services rendered shall be submitted in the format and frequency specified by the Division and/or

#### **Exhibit 7. Terms and Conditions Page**





### 3.5 BASIC INFORMATION COMPLETED PAGE

The **Basic Information Completed** page notifies you that the **Basic Information** page has been completed and provides instructions for resuming an In Process application, if you choose.

#### Basic Information Completed

🖨 | A- A+ | Help

✤ indicates a required field

ELECTRONIC SIGNATURE	?
Your <b>Electronic Signature PIN</b> will be sent to the email address provided on the Basic Information page. You will need this PIN to electronically sign this enrollment application upon submission. Your PIN will also be used to electronically sign future secure submissions.	N
[0r]	
Our records indicate that an <b>Electronic Signature PIN</b> has already been associated with this Office Administrator's NCID. Please use the current PIN to electronically sign this application upon submission If you have lost or forgotten your PIN, you will have the opportunity to reset it upon submission.	ı.
APPLICATION RETRIEVAL	?
You have successfully completed the basic information portion of the enrollment application.	
If you wish to retrieve and complete your saved application, use the Status Management link from the <u>Provider Enrollment Home</u> . You'll need your NCID and password to sign into the NCTracks portal. Please complete this application within 90 days for submission to the state. If it is not completed within 90 days, the incomplete application will be deleted.	e
	+
( Previous Next	; »
Application Last Updated: 2009-11-22 Save Draft Cancel Enrollmen	ıt

**Exhibit 8. Basic Information Completed Page** 

#### 3.6 HEALTH / BENEFIT PLAN SELECTION PAGE

The **Health / Benefit Plan Selection** page captures applicable health and benefit plans with begin and end dates. Authorized users can update health plan information.





TRACKET			Wecome, (LOL ou
			( ) NCTracket H
Provider Portal	Eligibility Prior Approval Claims Referral Code	Search Envolventy Administration Trading Partner Page	num Consent Forms Tasking
+ Huma + Provider Landbaust + Online Presi	oller Erendbrourt Ap		
Provider Enrollment	Health / Benefit Plan Selection		🚳 i 🗚 i tiele
NOTE: Cota is not saind unless the Next Sotton is activated.	<ul> <li>Indicates a required field</li> </ul>	5	Lagond -
Cranation firm before the	Which NC DHHS Health Plan(s) are you applying for What are the qualifications and requirements for the See Involve Terminology Matrix.	at this time? NC 01915 Health Plans?	
Intra and Coollines     Provide Intel®	Densen of Harth Boarns, Deside of Public Harth, Of	NEE OF BURAL HEALTH AND COMMUNITY CARE	1
[]] smethilbreidt Zhei, beischer	Rease select any coverage types for which you w	sh to erroll by checking the corresponding box.	
Denesite information	If you are a Behavioral Health provider intending	to contract with a Local Management Entity-Managed Car	e Organization (LME-MCD), contact the LME-MCD
Briest Assilution	If applying for Medicaid and/or NCHC (Children), / make the payment.	a \$500 NC Application fee will be required. Upon application	ion submission, you will be directed to Paypoint to
	Division of Health Benefits (DHB)     Medicald	NCHC (Children)	
•	Infant Todder	Sickle Cell	
	Early Hearing Detection Intervention	AIDS Drug Assistance Program	
	Office of Rural Health and Convenantly Care (OfficC)		
	ti Previous		Please be write to complete all <b>4</b> 1.30
			Save Droft, Delete Brat
	F PDF documents on this page require the free Adob	e Reader to view and print.	
6	About Lonal Minute According	No Cartal IN Sector Academics American	
	Auf Reseller And Manual Social Controls		

#### Exhibit 9. Health / Benefit Plan Selection Page

Step	Action
1	Do not opt out of coverage" under DHB. Division of Health Benefits (DHB): <b>Medicaid</b> and <b>NCHC (Children)</b> .
2	Opt out of any coverage by deselecting the appropriate checkbox: Division of Public Health (DPH): Infant Toddler, Sickle Cell, Early Hearing Detection Intervention, and AIDS Drug Assistance Program.
3	Opt out of any coverage by deselecting the appropriate checkbox: Office of Rural Health and Community Care (ORHCC): <b>Migrant Health</b> .
4	Select the Next button to continue.
Note	If a provider is enrolling as an OPR Lite and/or OOS provider, they will only see DHB health plans: <b>Medicaid</b> and <b>NCHC (Children)</b> .

#### **3.7 ADDRESSES PAGE**

The **Addresses** page captures the primary physical location, Pay-To/Remittance Advice (RA), correspondence, and other service location addresses and contact information. Servicing counties are captured for the primary physical location address and for each other servicing address entered.





Provider Portal	PORTAL-DEV			
• Home • Provider Enrollment • Online Provider	Enrollment Ap			
Provider Enrollment	Addresses			
NOTE: Data is not saved unless the 'Next' button is activated.	* indicates a required field			Legend 🔻
Contact EVC Center	PRIMARY PHYSICAL LOCATION			?
Individual Basic Information	This is the primary physical location	n where service will be rendered, or in the c	ase of mobile services, where management/supervision oc	curs.
Terms and Conditions     Previous Health Plan	1 * Office Phone #:	ext.	Office Fax #: (000) 000-0000	
Health/Benefit Plan Selection     Addresses	* Address Line 1: Address Line 2:			
Review Application	* City:	DURHAM -	* State: NC	

#### Exhibit 10. Addresses Page #1

Step	Action
1	Primary Physical Location: Enter the <b>Office Phone #</b> , <b>Office Fax #</b> , <b>Address</b> , <b>City</b> , and <b>State</b> . Select the <b>Verify Address</b> button (the address must correspond to an actual U.S. Postal Service address).

	_
1099 REPORTING/PAY-TO ADDRESS	?
All provider records with the same Employee Identification Number (EIN) must have the same 1099 Reporting Address. You only need to submit one application per EIN. Upon application approval, all records with the same EIN will be updated with the new address.	
* Do you have a separate Pay-To address?	
© Yes ⊙ No	
	+
	2
CORRESPONDENCE ADDRESS	
This is the address where all paper and accounting correspondence is to be mailed.	
* Do you have a separate correspondence address?	
© Yes ◎ No	
	+
	?
* Do you have additional service locations?	
© Yes ⊘ No	
	+

#### Exhibit 11. Addresses Page #2

Step	Action
2	Servicing Counties: You must select the checkboxes for all counties in which you will render services.
3	1099 Reporting/Pay-To Address: Do you have a separate Pay-To address?; Select <b>Yes</b> or <b>No</b> . <b>Note</b> : All provider records with the same EIN must have the same 1099 Reporting/Pay-To Address. If you need to update the address, submit an MCR application. You need to submit only one application per EIN. Upon application approval, all records with the same EIN will be updated with the new address.





SERVICE LOCATIONS			?
* Do you have additional service     • Yes     • No     Service Locations     Add Service Locations	) locations?		?
Please complete all the require	d fields and click the <b>Add</b> button.		
Service Location Name: * Office Phone #:	(000) 000-0000 ext.	Office Fax #:	(000) 000-0000
Address * Address Line 1:			
Address Line 2: * City:			
* State: * ZIP Code:		County	
			Verify Address
			5 Add Clear
			6 *
« Previous			Please be sure to complete all Next »

### Exhibit 12. Addresses Page #3

Step	Action
4	Service Locations: Do you have additional service locations? Select <b>Yes</b> or <b>No</b> . If <b>Yes</b> , enter <b>Office Phone #</b> , <b>Address, City</b> , <b>State</b> , and <b>ZIP Code</b> .
5	Select the Add button to add the service location.
6	Select the <b>Next</b> button to continue.
Note	HSOs providing services in multiple Pilot regions should indicate the offices in each of the regions (if applicable).





### 3.8 TAXONOMY CLASSIFICATION PAGE

The **Taxonomy Classification** page allows you to add taxonomy code sets (Provider Type, Classification, and Area of Specialization). Select the taxonomy code(s) under which you will be conducting business with NCTracks for each service location. Taxonomies that are identified as Moderate or High categorical risk levels will have additional enrollment criteria that must be met.

				Legend
vhich you will be conduct S) when you enumerate	ting business with NG d this NPI.	CTracks. All taxonon	nies selected should have b	een reported to th
IPPES, please report it w	ithin the next 30 day	/s.		
			Taxonomy Classification	
a or Specialization from	the ronowing drop-d	iown lists that best	describe the services you w	nii be rendering.
e Add button.				
ICE PROVIDERS	~			
ofessional	~			
	chich you will be conduct S) when you enumerate IPPES, please report it w a of Specialization from e Add button. ICE PROVIDERS ofessional	Arich you will be conducting business with NC S) when you enumerated this NPI. PPES, please report it within the next 30 day as of Specialization from the following drop-d e Add button. ICE PROVIDERS ofessional	<pre>/hich you will be conducting business with NCTracks. All taxonom S) when you enumerated this NPI. PPES, please report it within the next 30 days. a of Specialization from the following drop-down lists that best of e Add button. tcce providers  foressional </pre>	All taxonomies selected should have b S) when you enumerated this NPI.          PPES, please report it within the next 30 days.         Taxonomy Classification         ea of Specialization from the following drop-down lists that best describe the services you w         e Add button.         ICE PROVIDERS         v

axonomy Classification		🖨   A A   He
indicates a required field		Legend
Please select the Taxonomy Classific: National Plan & Provider Enumeration	tion(s) under which you will be conducting business with NCTracks. All taxonomies selected shoul System (NPPES) when you enumerated this NPI.	d have been reported to the
If a submitted taxonomy has not been	n reported to NPPES, please report it within the next 30 days.	
TYPE, CLASSIFICATION AND AREA OF SPI	CIALIZATION	3
You may enter up to 15 Taxonomy C Add Taxonomy Classification Please complete all the required file	dasalfications.	es you win de rendering.
<ul> <li>* Provider Type:</li> <li>* Classification:</li> <li>* Area of Specialization:</li> </ul>	AGENCIES	
		Add Clear

Exhibit 13. Taxonomy Classification Page





Step	Action
1	Add Taxonomy Classification: Using the drop-down menus, select <b>Provider Type</b> , <b>Classification</b> , and <b>Area of Specialization</b> (if applicable).
	If you are enrolling as an individual or atypical individual providers, select the following: <b>Provider Type:</b> Other Service Providers <b>Classification:</b> Prevention Professional <b>Area of Specialization:</b> None If you are enrolling as an organization or an atypical organization, select the following: <b>Provider Type:</b> Agencies <b>Classification:</b> Public Health or Welfare <b>Area of Specialization:</b> None
2	Select the <b>Add</b> button to add another Taxonomy Classification. <b>Note</b> : Repeat this process to add multiple taxonomy codes. You can enter up to 15 taxonomy codes.

### 3.9 HSO SERVICES PAGE

The **HSO Services** page captures services information. This page displays only for Human Services Organizations.

Provider Portal	Eligibility Prior Approval Claim	ns Referral Code Search <u>Enrollment</u> A	Idministration Trading Partner	Payment Consent Forms Training	PORTAL-DEV
• Home • Provider Enrollment • Online Provid	der Enrollment Ap				
Provider Enrollment	Health Service Organ	ization (HSO) Services			AA Help
NOTE: Data is not saved unless the 'Next' button is activated.	indicates a required field				Legend w
Contact CSRA Call center	- SERVICE LOCATIONS				
📝 Individual Basic Information	Select	L.	ocation		Form Status
Terms and Conditions		and the second			V Complete
Provious Health Plan	O				Complete 2
Health/Benefit Plan Selection	To complete information for eac	h service location, select the appropriate	location then click the "Edit Lo	cation" button.	•
🖌 öddesses					Edit Location
Taxonomy Classification					
Health Service Organization (HSO) Services	Health Service Organization	(HSO) Services:			
Accreditation	HEALTH SERVICE ORGANIZATION	HSO) SERVICES			
Hours of Operation	* Select one or more HSO ser	vices provided at this service location.			
Services	Housing				
Boenta/Manaoing Employees	Interpersonal Safety or Te     Ecod and Nutrition	xic Stress			
Heavital Admitting	Transportation				4
Method of Clain/Electronic Submission					
Affiliated Provider Information					Save Location
EFT Account Information					
Supplemental Information	(( Previous			Please be sur required fields w	to con 5 Next 3
Exclusion Sanction Information					
Beview Application					Save Draft Delete Draft

### Exhibit 14. HSO Services Page

Step	Action
1	Add Service Location: Select the radio button beside each service location.
2	Select the Edit Location button.





Step	Action
3	Select one or more of the following services provided at each location: <b>Housing</b> , Interpersonal Safety or Toxic Stress, Cross Domain, Food and Nutrition, Transportation.
4	Select Save Location.
5	Select Next.

#### **3.10 ACCREDITATION PAGE**

The Accreditation page allows you to add relevant accreditations, certifications, and licenses.

Based on the location, health plans, and taxonomies that you selected in the application, required accreditation, certification, and/or license fields will be populated. You must complete the remaining required fields.

You can add additional accreditations, certifications, and/or licenses as desired.

Once a Clinical Laboratory Improvement Amendments (CLIA) or Drug Enforcement Agency (DEA) certification is added to a provider record and verified, CSRA will update the effective dates according to information received from those certifying agencies.

Licenses issued by the NC Medical Board for Medical Doctors, Physician Assistants, and Anesthesiologists will also have the effective dates automatically updated once they have been verified as active by CSRA.

**Note:** If you are enrolling with only an HSO taxonomy code, there is no required accreditation, certification, or license.

Accreditation					
* indicates a required field					Legend 🔻
Add Accreditation Add Accreditation Select an accreditation type from t	he drop down list and provide tl	he accreditation numbe	r.		?
Accreditation Type: Accreditation #: Effective Date:	Select One		Expiration Date:	mm/dd/yyyy	2 Add Clear
CERTIFICATIONS Add Certification					?
In addition to certifications require Select a certification type from the	d for a taxonomy code, enter al drop down list and provide the	l additional board certif certifying entity and ce	ications. ertification number.		
Certification Type: Certifying Entity: State: Certification #: Effective Date:	Select One Select One Select One mm/dd/yyyy	>	Expiration Date:	mm/dd/yyyy	 4
					Add Clear

Exhibit 15. Accreditation Page #1





Step	Action
1	Add Accreditation: Enter <b>Accreditation Type</b> , <b>Accreditation #</b> , <b>Effective Date</b> , and <b>Expiration Date</b> . If your accreditation does not have an expiration date, leave this field blank.
2	Add Certification: Enter <b>State</b> , <b>Certification #</b> , <b>Effective Date</b> , and <b>Expiration Date</b> . If your certification does not have an expiration date, leave this field blank.

LICENSES					
Taxonomy 237700000X - Hearin	<b>ig Instrument Specialist</b> require	es the following License T	Гуре:		
LICENSED AUDIOLOGIST By S	tate Board of Examiners for Spe	ech & Language Patholog	jists & Audiologist	s, OR	
LICENSED HEARING AID DEAL	ER & FITTER By State Board of H	Hearing Aid Dealers and F	itters		
- LICENSE - LICENSED HEARI	NG AID DEALER & FITTER By	STATE BOARD OF HEAR	RING AID DEALER	s and Fitters	
Lisense Asensu	State Reard of Hearing Aid I	Deploys and Fitters			
License Agency:					
License Type:					
License #:	32185				
Effective Date:	11/22/2019	E	xpiration Date:	12/31/2020	
				,,	
					Delete Edit
Add License					
Select a license type from the dr	op down list and provide the lice	ense number.			
5 License Agency:	Select One	•			
License Type:	Select One	•			
State:	NORTH CAROLIN -				
License #:					
Effective Date:	mm/dd/yyyy 🔣	E	Expiration Date:	mm/dd/yyyy	6
					Add Clear

## Exhibit 16. Accreditation Page #2

Step	Action
5	Add License: Select License Agency, select License Type, and enter State, License #, Effective Date, and Expiration Date.
6	Select the Add button.





#### 3.11 HOURS PAGE

The **Hours** page captures the hours that services are provided on a regular basis and afterhours coverage information. (If Applicable)

O Yes O NO					
Please indicate the hours weekdays by dicking the	s each day a provider is ava • ' <b>Copy</b> ' link. Totals will be c	ilable to see recipients at th alculated automatically.	nis location. Monday hours	may be copied to the rem	naining
Note: The total number	of hours entered must be (	greater than zero.			
Day	From	to	Erom	to	Tot
Monday Conv 🔏	8:00 AM	12:00 PM V	Select V	Select V	4
Tuesday	8:00 AM	12:00 PM	Select 💙	Select 💙	4
Wednesday	8:00 AM	12:00 PM	Select 💌	Select 💌	4
Thursday	8:00 AM	12:00 PM 💌	Select 💌	Select 💌	4
Friday	8:00 AM	12:00 PM 💌	Select 💌	Select 💌	4
Saturday	Select 💌	Select 💌	Select 💌	Select 💌	0
Sunday	Select 💌	Select 💌	Select 💌	Select 💌	0
		Total hours per week			20
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce	(PCPs) must be available at ticipation guidelines. Please ption:	each practice site a minimu enter your reason for exce	im of 30 hours per week. ption in the CCNC/CA Exc	Your total number of offic eption box. Approval for t	e hours da che except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce	(PCPs) must be available at ticipation guidelines. Please ption:	each practice site a minimu enter your reason for exce	im of 30 hours per week. ption in the CCNC/CA Exc	Your total number of offic eption box. Approval for t	e hours do
CCNC/CA Exception Primary Care Providers not met CCNC/CA par is not a guarantee. 2 * Exce After-Hours Coverage	(PCPs) must be available at ticipation guidelines. Please ption:	lotal hours per week each practice site a minimu enter your reason for exce	im of 30 hours per week. ption in the CCNC/CA Exc	Your total number of offic eption box. Approval for t	e hours da
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce After-Hours Coverage Noto to CCNC/CA par	(PCPs) must be available at hidpation guidelines. Please ption:	each practice site a minimu enter your reason for exce	im of 30 hours per week. ption in the CCNC/CA Exc	Your total number of offic eption box. Approval for t	e hours do
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA pro- automatically to the Em	(PCPs) must be available at tidpation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho	r will be the number that a spital Switchboard is not as	im of 30 hours per week. ption in the CCNC/CA Exc 	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours do he except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA pro- automatically to the Em	(PCPs) must be available at tridpation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho:	r will be the number that a	im of 30 hours per week. ption in the CCNC/CA Exc 	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours do he except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA pro- automatically to the Em 3 * After-hours on Responder Pho-	(PCPs) must be available at tridipation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho: r 24/7 (919) 333-4444 ne #:	r will be the number that a ext.	im of 30 hours per week. ption in the CCNC/CA Exc ppears on a recipients Mec ceptable.	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours du the except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA pro- automatically to the Em 3 * After-hours on Responder Pho-	(PCPs) must be available at tridipation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho: r 24/7 (919) 333-4444 ne #:	r will be the number that a ext.	im of 30 hours per week. ption in the CCNC/CA Exc ppears on a recipients Mec ceptable.	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours do he except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA pro- automatically to the Em 3 * After-hours or Responder Pho- * Type of after-hours or 2 Answering Service	(PCPs) must be available at tridipation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho: 24/7 (919) 333-4444 ine #:	r will be the number that a spital Switchboard is not ac	im of 30 hours per week. ption in the CCNC/CA Exc ppears on a recipients Mec ceptable.	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours da he except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce After-Hours Coverage Note to CCNC/CA pr automatically to the Em 3 * After-hours or Responder Pho * Type of after-hours or 2 Answering Service Phone message th	(PCPs) must be available at tridipation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho: 24/7 (919) 333-4444 ine #: 4/7 responder coverage: st gives number of provide	r will be the number that a ext.	im of 30 hours per week. ption in the CCNC/CA Exc ppears on a recipients Mec ceptable.	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours do
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce After-Hours Coverage Note to CCNC/CA pr automatically to the Em 3 * After-hours or Responder Pho * Type of after-hours or Answering Service Phone message th Hospital onerator	(PCPs) must be available at tridipation guidelines. Please ption: pviders: The phone numbe ergency Department or Ho: 24/7 (919) 333-4444 ine #: 4/7 responder coverage: that gives number of provide	r will be the number that a spital Switchboard is not ac	im of 30 hours per week. ption in the CCNC/CA Exc ppears on a recipients Mec ceptable.	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours do he except
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce After-Hours Coverage Note to CCNC/CA pr automatically to the Em 3 * After-hours or Responder Pho * Type of after-hours or Call prover or st Call forward or st	(PCPs) must be available at tridipation guidelines. Please ption: prion: (919) 333-4444 (77 responder coverage: that gives number of provider who pages on-call provider av-on-line transferring	r will be the number that a spital Switchboard is not ac ext.	im of 30 hours per week. ption in the CCNC/CA Exc pears on a recipients Mec ceptable.	Your total number of offic eption box. Approval for t icaid Identification (MID) o	e hours do
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA pr automatically to the Em 3 * After-hours or 3 * After-hours or 3 * After-hours or 1 Answering Service Phone message th Hospital operator Call forward or sta Nurse Triage Serve	(PCPs) must be available at tridipation guidelines. Please ption: ergency Department or Ho: 24/7 (919) 333-4444 ine #: 4/7 responder coverage: that gives number of provider ay-on-line transferring ice	r will be the number that a spital Switchboard is not ac ext.	im of 30 hours per week. ption in the CCNC/CA Exc pears on a recipients Mec xeptable.	Your total number of offic aption box. Approval for t icaid Identification (MID) o	e hours do
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA par automatically to the Em 3 * After-hours or 3 * After-hours or 3 * After-hours or 3 Answering Service Phone message th Hospital operator Call forward or sta Nurse Triage Serv 2 4 hour hospital	(PCPs) must be available at tridipation guidelines. Please ption: prion: (919) 333-4444 (77 responder coverage: that gives number of provider ay-on-line transferring ice witchboard	r will be the number that a spital Switchboard is not ac ext.	im of 30 hours per week. ption in the CCNC/CA Exc pears on a recipients Mec xeptable.	Your total number of offic aption box. Approval for t icaid Identification (MID) o	e hours do
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA par automatically to the Em 3 * After-hours or 3 * After-hours or 3 * After-hours or 3 * After-hours or 3 Call forward or sta Nurse Triage Serv 2 4 hour hospital service ER Triage	(PCPs) must be available at tridipation guidelines. Please ption: prion: (919) 333-4444 (77 responder coverage: that gives number of provider ay-on-line transferring ice witchboard	r will be the number that a spital Switchboard is not ac ext.	im of 30 hours per week. ption in the CCNC/CA Exc pears on a recipients Mec xeptable.	Your total number of offic aption box. Approval for t icaid Identification (MID) o	e hours do
CCNC/CA Exception Primary Care Providers not meet CCNC/CA par is not a guarantee. 2 * Exce A fter-Hours Coverage Note to CCNC/CA par automatically to the Em 3 * After-hours or Call forward or sta Durse Triage Service ER Triage Phosician on call	(PCPs) must be available at tridipation guidelines. Please ption: providers: The phone numbe ergency Department or Ho: 24/7 (919) 333-4444 ine #: 4/7 responder coverage: that gives number of provider ay-on-line transferring ice witchbo ard	r will be the number that a spital Switchboard is not ac ext.	im of 30 hours per week. ption in the CCNC/CA Exc pears on a recipients Mec xeptable.	Your total number of offic aption box. Approval for t icaid Identification (MID) o	e hours do

#### Exhibit 17. Hours Page

Step	Action
1	Click the appropriate radio button beside <b>Does this Facility operate 24/7?</b> If <b>No</b> is selected, enter the hours of operation. (If Applicable)
2	If the provider operates for less than a minimum of 30 hours per week, enter an explanation in the <b>Exception</b> box.
3	Enter the appropriate phone number in the After-hours or 24/7 Responder Phone # box.
4	Indicate the type of after-hours or 24/7 responder coverage.
5	If Other is selected as the type of after-hours or 24/7 responder coverage, enter a description in the <b>Describe 'Other'</b> box.





### **3.12 SERVICES PAGE**

The **Services** page captures the types of services that are provided.



#### **Exhibit 18. Services Page**

Step	Action
1	Click the appropriate radio buttons beside Are Oral Interpretation Services Available, Is Braille Supported and Is Sign Language Supported.
2	Indicate the languages supported in office. Highlight the supported language and select the <b>Add</b> button to add it to the <b>Selected Options</b> box.
3	Click the check box next to the Special Needs services offered, if applicable.
4	Click the appropriate radio buttons in the New Patients Accepted section.
5	Indicate the appropriate choice in the <b>Medicaid for Pregnant Women</b> section. <b>Note:</b> HSOs would select option 2 "I serve both MPW and Medicaid patients".





#### 3.13 AGENTS AND MANAGING EMPLOYEES PAGE

The **Agents and Managing Employees** page captures managing relationships. A managing relationship is between the provider and an employee (i.e., general manager, business manager, administrator, director, or other person who exercises operational or managerial control of a provider, or who directly or indirectly conducts the day-to-day operations of a provider).

Note: Agents and managing employees list should only include HSO staff working on the Pilots.

				Lege
ELATIONSHIP DISCLOSURE				
s required by 42 CFR 1002.3, nember, and Electronic Funds ailure to provide the required	, providers must o Transfer (EFT) a I information may	disclose the following for each individual officer authorized individual. result in a denial for participation.	, managing employee, dir	ector, boa
★ Does the applicant have an ④ Yes ◎ No	y agent(s) and/o	or managing employee(s)?		
Managing Relationships				
Please add all managing relat	ionships below.			
- MANAGING RELATIONSHI	р - Ѕмітн, Јонн			
Last Name:	Smith	First Name:	John	
Middle Name:		Suffix:		
Date of Birth:		SSN:		
Business Relationship:	Officer	Relationship to Another Disclosing Person:	Child	
☑ I attest that I have	entered the full l	egal name of the individual, and the individual o	does not have a middle n	ame. 2
I attest that I have  Add Relationship  Please complete all the requi	entered the full le	egal name of the individual, and the individual o	does not have a middle n	ame. 2
I attest that I have Add Relationship Please complete all the requ # Last Name:	entered the full k	egal name of the individual, and the individual of the control of	does not have a middle n.	ame. 2
I attest that I have  Add Relationship  Please complete all the requ  # Last Name: Middle Name:	entered the full k ired fields and cli	egal name of the individual, and the individual of the Add button to save.	does not have a middle n	ame. 2
I attest that I have  Add Relationship  Please complete all the requ  K Last Name: Middle Name: K Date of Birth: K Date of B	entered the full li	egal name of the individual, and the individual of ck the Add button to save. (Enter your full middle name) Suffix: SSN:	does not have a middle n.	ame. 2
I attest that I have  Add Relationship  Please complete all the requ  # Last Name: Middle Name: * Date of Birth: * Business Relationship:	entered the full le ired fields and clie [ mm/dd/yyyyy [ - Select One	egal name of the individual, and the individual of ck the Add button to save. K First Name: (Enter your full middle name) Suffix: K Relationship to Another Disclosing Person:	does not have a middle n 	ame. 2
I attest that I have  Add Relationship  Please complete all the requ  K Last Name:  K Last Name:  K Date of Birth:  Business Relationship:  I attest that I have of	entered the full li	egal name of the individual, and the individual of ck the Add button to save. (Enter your full middle name) Suffix: KRelationship to Another Disclosing Person: bgal name of the individual, and the individual d	does not have a middle n Select One Select One Select One Select One oos not have a middle na	ame. 2
I attest that I have  Add Relationship  Please complete all the requ  # Last Name: Middle Name: * Date of Birth: * Business Relationship:  I attest that I have of	entered the full le	egal name of the individual, and the individual of ck the Add button to save. (Enter your full middle name) Suffix: S * Relationship to Another Disclosing Person: agal name of the individual, and the individual d	does not have a middle n - Select One - • 000-00-0000 - Select One - • 000-00 a middle na	ame. 2 Edit

#### Exhibit 19. Agents and Managing Employees Page

Step	Action
1	Relationship Disclosure: Does the applicant have any agent(s) or managing employee(s)? Select <b>Yes</b> or <b>No</b> ; if <b>Yes</b> , the <b>Managing Relationship</b> section displays.
2	Select the <b>Edit</b> button to edit an existing Managing Relationship to change <b>Last Name</b> , <b>First Name</b> , <b>Middle Name</b> , <b>Suffix</b> , <b>Date of Birth</b> , <b>SSN</b> , <b>Email</b> , <b>Phone Number</b> , and <b>Business Relationship</b> .
3	In the Add Relationship section: Complete the fields Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Email, Phone Number, Business Relationship, Address, City, State, and ZIP Code. If applicable, select the checkbox: I attest that I have entered the full legal name of the individual, and the individual does not have a middle name. Select the Add button.
4	Select the Next button to continue.





#### 3.14 METHOD OF CLAIM AND ELECTRONIC TRANSACTIONS PAGE

The **Method of Claim and Electronic Transactions** page captures how you will be submitting and/or receiving electronic transactions.

HSO-only providers will not be submitting claims directly to NCTracks. However as a default selection, please select the first option 'Submit a single claim via the NCTracks Provider Portal."

However, if the individual selected YES to the rendering/attending only question on the Individual Basic Info Page, this page will not display.

**Note**: For more information on the Abbreviated MCR options, refer to Participant User Guide PRV 563 *Abbreviated Managed Change Request*. Users with the Enrollment Specialist user role can submit all abbreviated MCRs except EFT. The OA and Owner/Managing Employee users can submit all abbreviated MCRs including the EFT abbreviated MCR.

indicates a required field	Legend
* Method of Transaction	
Please select how the enrolling billing agent will be sending and receiving claims. (Select all that apply)	
☑ Submit a single claim via the NCTracks Provider Portal	
Submit a batch claim via NCTracks	
Billing Agent	8
Previous	Please be sure to complete all Next 1 required fields with valid content.

Save Draft Delete Draft

#### Exhibit 20. Method of Claim and Electronic Transactions

Step	Action
1	Click the appropriate check box(es) in the <b>Method of Transaction</b> section.
2	Select the <b>Next</b> button.

#### 3.15 EFT ACCOUNT INFORMATION PAGE

The **EFT Account Information** page captures EFT and Remittance information. All payments are by EFT in NCTracks.

**Note:** Atypical individual providers will be rendering/attending only providers and we will not be collecting EFT Account Information. If an individual selected YES to the rendering/attending only question on the Individual Basic Info Page, this page will not display





### EFT Account Information

✗ indicates a required field					Ler	gend 🔻
- ACCOUNT INFORMATION						?
* Routing Number:						
* Account Number:			* Account Nu Confirm	umber ation:		
* Account Type:	Select One 🔹					
* Bank Name:				]		
* Bank Address Line 1:				]		
Bank Address Line 2:				]		
* City:						
* State:	NORTH CAROLINA	-				
* ZIP Code:	00000-0000					
					Verify A	ddress
						2 *
« Previous				Please be sure to required fields with v	complete all alid content.	Next »
				Save Draft	Cancel En	rollment

#### Exhibit 21. EFT Account Information Page

Step	Action
1	Enter the account information.
2	Select the <b>Next</b> button.
	<b>Note:</b> Atypical individual providers will be rendering/attending only providers and we will not be collecting EFT Account Information. If an individual selected <b>YES</b> to the rendering/attending only question on the Individual Basic Info Page, this page will not display.





#### 3.16 EXCLUSION SANCTION INFORMATION PAGE

		Legend
Evenue		
The que	Sanction information -	6 and 42 CEP
1002.3.	Auna below must be answered for the emoling provider, its owners, and agents in accordance with 42 Crit 455,100, 101, 104, 10	o and 42 CFK
<ul> <li><sup>†</sup>An</li> <li>gen</li> <li>boa</li> </ul>	agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This may include ma eral managers, business managers, office managers, administrators; Electronic Funds Transfer (EFT) authorized individuals, individu d members, etc.	naging employe al officers, direc
• All a	pplicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.	
For each clearly in	question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, and, dicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this ap	or final disposit plication.
<ul> <li>A. Has felony, or</li> <li>Yes</li> </ul>	the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled entered into a pre-trial agreement for a felony? ONo	no contest to a
Please a	dd up to 5 Infraction/Conviction Dates.	
= INF	ACTION/CONVICTION DATES	
0 09/0	Infraction/Conviction Date 1/1999	
🔁 mm	′dd/yyyy ₹	
		Add
iny other certifying provided, OYes	state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found b or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the qu or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency? No	y a licensing, uality of services
rom Med or profess private he	care, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a co- ional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any or apple provides the babble provides to babble provides and any other state of the state of the state of the state	rporation, busin ther governmen
ealth ins	and care of heard care of heard madrance programmany scare, or ever been directly or interectly annated into a provider of suppl (a excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care of urance program in any state? ● No	plier that has be or health care or
vestant of the second of	and call of head head insurance program in any scale, or ever been directly or induced annaed with a provider or suppl (a exclude d, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or urance program in any state? ● No It he applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or b n, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state; or ever been dir with a provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state? ● No	plier that has be or health care or een employed b ectly or indirect
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Suspende health ins OYes D. Has corporation affiliated OYes K. Has or Program OYes K. F. Doo affiliated OYes	and care of heard heard mean management of the set of the set of the set of the set of heard heard mean management of the set of heard mean management of the set of heard means and care of the set of heard means and care of the set of heard management and the set of the set	plier that has be or health care or eeen employed b ectly or indirect ite or Federal Ag directly or indire
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#### Exhibit 22. Exclusion Sanction Information Page

Page





Step	Action
1	Select <b>Yes</b> or <b>No</b> for each Exclusion Sanction question. When <b>Yes</b> is selected for a question, the <b>Infraction/Conviction Dates</b> section displays. Select the <b>Add</b> button to add an Infraction/Conviction Date.
	For each question answered <b>Yes</b> , you must attach or submit a complete copy of the applicable criminal complaint or disciplinary action, Consent Order, documentation regarding recoupment/repayment settlement action, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application.
	Disclosure of adverse legal actions may not preclude participation with the NC Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the NC Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).
	<b>Note</b> : All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.



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#### 3.17 REVIEW APPLICATION PAGE

Selecting the **Review Application** button displays a window that will allow you to open a PDF file of your application, which you can print and review for accuracy before submitting.

Review Application	🖨   A- A+   Help
ELECTRONIC SIGNATURE - EMAIL CONFIRMATION	
<ul> <li>Please confirm that the email address below is correct. If you don't already have Electronic Signature PIN will be sent to this address upon submitting the next access to this email address to retrieve/reset your PIN and complete this Online</li> <li>If the email below is incorrect, you may now navigate back to the <u>Basic Informa</u> update it. (Remember to click 'Next' on the <u>Basic Information page</u> to store your change.)</li> </ul>	e one, an page. You will need Application. <u>tion page</u> to
Contact Email: abc@123.com	
REVIEW APPLICATION	
To review your application in Adobe PDF format, click ' <b>Review Application</b> ' below. If successfully completed all required information for your provider enrollment application the information is complete and accurate, you may proceed to the Attachments/Sub Application page by clicking ' <b>Next</b> '.	f you have on and are satisfied omit Electronic
Review	v Application ⊱
	2 *
« Previous	Next »

#### Exhibit 23. Review Application Page

Step	Action
1	Select the Review Application button.
2	Select the <b>Next</b> button to continue.

#### 3.18 APPLICATION SAVED PAGE

This page displays when the application is saved.

#### Application Saved

🖨 | A- A+ | Help

Γ	Application Retrieval	?
	Your application has been saved. If you wish to retrieve and complete your saved application, please use the NCID entered on the Basic Information page and NCID password to sign in to the NCTracks portal. Your saved application will be displayed in the 'Saved Application' section of the Status Management Page.	
	Please remember that your application must be completed and submitted to the State within 90 days of the date it was created. If not completed within 90 days the incomplete application will be deleted.	

#### Exhibit 24. Application Saved Page





### **3.19 FINAL STEPS PAGE**

The **Final Steps** page informs you that the application submission is complete. This page also contains the final steps you must take in order to complete the application process (supplemental documents required). You can also download a PDF copy of the submitted application. If a provider is required to complete the fingerprinting process as identified in the Provider Permission Matrix, they will be notified on this page.

If the application is deemed incomplete or if additional information is required, the provider will receive a notification letter indicating that they will have 30 days to submit the required information or the application will be abandoned. If documentation is received timely but is inadequate, the provider will be notified and given an additional 10 days to submit the required information. If the information is received and reviewed and it is still inadequate, the provider will be notified and given an additional 10 days. If the correct information is not received the third time, the application will be abandoned and the provider will have to resubmit the application. If no documentation is received after the first 30-day notice or either of the 10-day notices, the application will be abandoned.

The OA/ES user will have access to the notification letters via the Message Center inbox as well as a hyperlink on the **Status and Management** page.

If the application is denied, the notification letter will be sent via e-mail.

HSOs will have the opportunity to use capacity-building funds to cover the application fee.





#### Final Steps

indicates a required field	Legend
ONLINE SUBMISSION COMPLETE	
Thank you for submitting the online portion of your application. Please save/print the following documents for your records	
Online Application     Cover Sheet     Review Agreement	
Now that you have submitted your online application, you will not be able to retrieve the application or reprint applica	tion documents.
APPLICATION FEE REQUIRED	
Thank you for applying to Medicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC App 'Pay Now' button. You will be directed to Paypoint to make the payment.	lication Fee is required. Please click the
FINGERPRINTING REQUIRED	
FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See <u>Fingerprinting Information Page</u> for more information.	ou submitted requires fingerprinting. Afte for completing the fingerprinting process
FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See <u>Fingerprinting Information Page</u> for more information. REQUIRED ATTACHMENTS	ou submitted requires fingerprinting. Afte for completing the fingerprinting process
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FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See <u>Fingerprinting Information Page</u> for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: • PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Me	ou submitted requires fingerprinting. Afte for completing the fingerprinting process mtal Health
FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Me The following documents are required with your Provider Enrollment Application. They can be submitted electronically	ou submitted requires fingerprinting. Afte for completing the fingerprinting process untal Health y and/or by regular mail.
FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Me The following documents are required with your Provider Enrollment Application. They can be submitted electronicall No Required Attachments for the Taxonomy	ou submitted requires fingerprinting. Afte for completing the fingerprinting process intal Health y and/or by regular mail.
FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: • PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Me The following documents are required with your Provider Enrollment Application. They can be submitted electronicall • No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS	ou submitted requires fingerprinting. Afte for completing the fingerprinting process intal Health y and/or by regular mail.
FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application y your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: • PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Me The following documents are required with your Provider Enrollment Application. They can be submitted electronicall • No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button be attachments on the Status Management Page.	ou submitted requires fingerprinting. Afte for completing the fingerprinting process intal Health y and/or by regular mail.

PDF documents on this page require the free Adobe Reader to view and print.

#### Exhibit 25. Final Steps Page

Step	Action
1	Print/save the <b>Online Application</b> and/or <b>Cover Sheet</b> . This will be the only opportunity to save, download, or print the PDFs.
2	Select the <b>Pay Now</b> button. The PayPoint landing page displays. See <u>Addendum B</u> to view the PayPoint process. <b>Note</b> : Application Fee Required: A \$100 NC Application Fee is required when applying for Medicaid and/or NCHC.
3	Fingerprinting Required: This section will display if the application requires fingerprinting. Not applicable to HSO-only providers
4	Required Attachments: Review the list of documents that need to be included with the application.
5	Select the <b>Upload Documents</b> button if any electronic attachments need to be submitted.



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# 4.0 Re-verification

Most providers are required to provide a Re-verification application every five years; however, providers with HSO-only taxonomy codes are exempt from Re-verification.



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# 5.0 Maintain Eligibility

If providers have not had any claim activity within the last 12 months, providers are required to complete a Maintain Eligibility application if they intend to stay active. The Notification of Inactivity Letter is sent to the provider's Message Center inbox if the provider has not had any claim activity within the last 12 months. If the application is not submitted, the provider will be terminated. A Termination Letter will be mailed to the provider. The provider will be required to re-enroll if they wish to participate.



North Carolina Medicaid Management Information System (NCMMIS)



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