

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



**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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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.

- [Initial Enrollment](#) – You will complete an initial Enrollment application if you want to newly enroll with NC DHHS.
- [Re-verification](#) – 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.
- [Maintain Eligibility](#) – 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

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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.

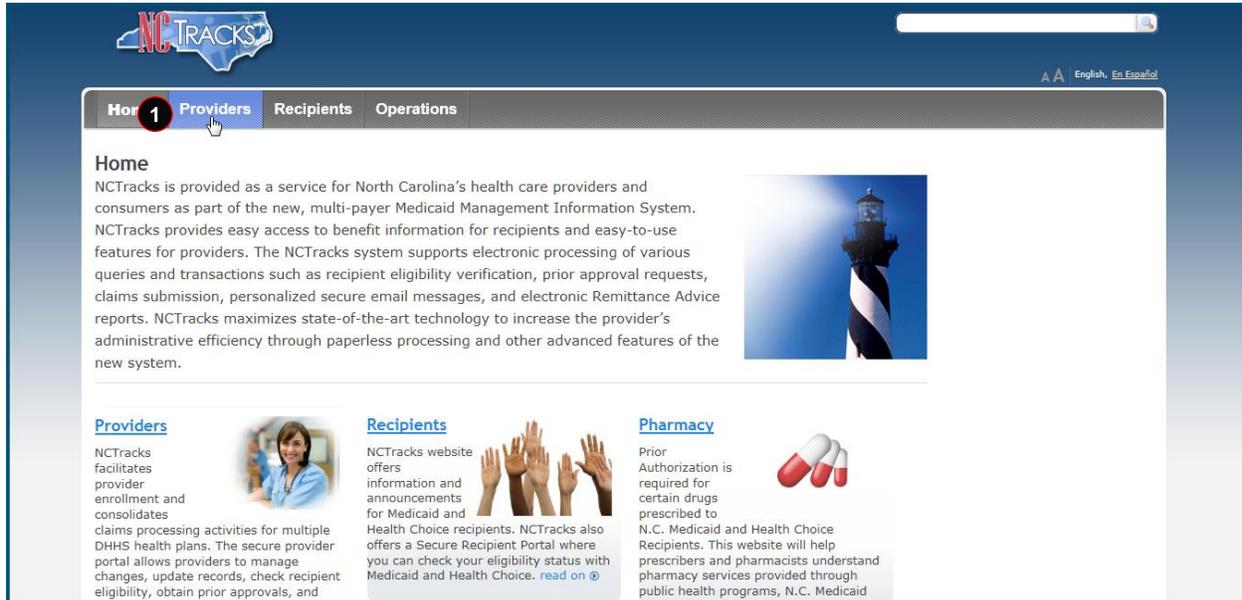


Exhibit 1. NCTracks Home Page

Step	Action
1	Select the Providers link. The public Providers page displays.

Home
Providers
Recipients
Operations

[Home](#) > [Providers](#) > Provider Enrollment

- Getting Started With NCTracks
- Provider Communication
- Frequently Asked Questions
- Currently Enrolled Provider (CEP) Registration
- Claims
- Prior Approval
- 1** **Provider Enrollment**
- 2** **Getting Started With Enrollment**
- Supporting Information
- Terms and Conditions
- Enrolled Practitioner Search
- ICD-10
- Provider Re-credentialing/Re-verification
- Provider Policies, Manuals, Guidelines and Forms
- Provider User Guides and Training

Provider Enrollment

NC DHHS recognizes the need to promote access to care by enrolling all providers in a timely manner and is committed to ensuring the provision of quality care for our citizens.

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 and may begin submitting claims to NC DHHS for services rendered.

The CSRA Enrollment Team cannot provide special consideration for processing of enrollment applications due to provider error, incomplete information, or due to a delay in obtaining credentialing, endorsement or licensure information from another agency.

Applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as DHHS providers. Specific qualifications for each provider type are listed in the [Provider Registration Manual](#).

[Fingerprinting Information Page](#)

This page includes a list of answers to frequently asked questions (FAQs) and other resources regarding provider fingerprint-based criminal background checks. [read on >](#)

Contact

CSRA Call Center

Provider Enrollment
2610 Wycliff Road, Suite 100
Raleigh, NC 27607

Work **800-688-6696**
Fax **855-710-1965**

E-Mail
NCTracksprovider@ncctracks.com

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.

Exhibit 3. Getting Started Page

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

Exhibit 4. NCTracks Login Page

Step	Action
1	User ID (NCID): Enter your NCID . 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 <i>Enrollment Specialist User</i> .

Step	Action
2	Password: Enter your Password .
3	Select the Log In button. The Provider Portal displays.
Note	<p>Select the NCID link only if provider (the OA) does not have an NCID.</p> <p>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</p> <ul style="list-style-type: none"> • Desired username • First Name • Last Name • Email Address • Mobile Number (Not Required but recommended) • New password <ul style="list-style-type: none"> • Password is case sensitive. • Must be at least 8 characters long. • 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: <ul style="list-style-type: none"> • 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. • Click Continue
Note	<p>Passwords are case-sensitive. After three unsuccessful attempts, the user will be locked out; 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.</p>

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

Contact Information

If you have any questions regarding completion of Provider Enrollment, please contact CSRA Call Center.

Phone: **800-688-6696**
 Fax: **855-710-1965**
 Email: NCTracksProviders@ncctracks.com

Quick Links

[Status and Management](#)

[Provider Enrollment Home](#)

[PE Supporting Information](#)

[PE Terms and Conditions](#)

[Batch Enrollment Upload](#)

[Batch Enrollment Status](#)

Online Provider Enrollment Application

* Indicates a required field

PROVIDER LOCATION

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:

PROVIDER ENROLLMENT APPLICATION TYPE

Individual

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 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.

Organization

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 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 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.

Billing Agent

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.

Please be sure to complete all required fields with valid content.

Exhibit 5. Online Provider Enrollment Application Page

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

PUG_HSO0002

REVIEW/ACCEPT
 PUG_HSO002_HSO Enrollment_D1.0.1

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3.3 ORGANIZATION BASIC INFORMATION PAGE

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

Organization Basic Information Legend

* indicates a required field

1 IDENTIFYING INFORMATION

* Organization Name:

* EIN: * NPI:

* Email: * Month of Fiscal Year End:

2 DOING BUSINESS AS (DBA)

* Do you operate under a trade or company name?
 Yes No

3 OWNERSHIP INFORMATION

* Business Type:

4 OFFICE ADMINISTRATOR (AUTHORIZED INDIVIDUAL)

Individual authorized to receive information or make business decisions on behalf of applying provider. This role currently belongs to the person populated below.

* User ID (NCID):

* Last Name: * First Name:

Middle Name: Suffix:

(Enter your full middle name)

* Contact Email: * SSN:

* Office Phone #: ext. Office Fax #:

I attest that I have entered the full legal name of the individual, and the individual does not have a middle name.

5 EFFECTIVE DATE REQUESTED

The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment may not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received and may not precede, as applicable, the current date of your licensure or the current date of your letter of endorsement.

Note: CCNC/CA participation effective date may not be retroactively requested.

* Effective Date:

I attest that the Requested Effective Date is correct and understand that it cannot be changed once the application is submitted.

Please be sure to complete all required fields with valid content. Next >>

Exhibit 6. Organization Basic Information Page

Step	Action
1	Identifying Information: Enter Organization Name, EIN, NPI, Email, and Month of Fiscal Year End.
2	Doing Business As (DBA): Answer Yes or No to the question: “Do you operate under a trade or company name?” . <ul style="list-style-type: none"> If you answer Yes, the field will expand, prompting you to enter the DBA Name and Years

Step	Action
	<p>Doing Business Under This Name. Note: The DBA Name must be registered in the county where the service is being provided.</p> <ul style="list-style-type: none"> If you answer No, you may continue to the next required field on the page.
3	<p>Ownership Information: Select the Business Type from the drop-down menu:</p> <ul style="list-style-type: none"> City/Municipality: Select this if the Organization is owned by a City or a Municipality. Corporation: Select this if this is a legal entity that is separate from the people who own it. Shareholders govern the corporation indirectly by electing people to manage it. Federal: Select this if ownership falls within the jurisdiction of the federal government. Indian Health Services: Select this if the ownership falls within the jurisdiction of the Indian Health Services. Limited Liability Corporation: Select this (filing status) if this is a Limited Liability Corporation (LLC). Local Government Agency: Select this if the Organization is owned by a City or a Municipality. Non-Profit: Select this if it is a non-profit enterprise. Partnership: Select this if it is a General Partnership, or a Limited Partnership, where two or more people have created this business entity. State: Select this if the entity is owned by the state in which it operates.
Note	<p>The Organization Name and DBA Name fields only allow the following characters:</p> <ul style="list-style-type: none"> Alpha (A – Z) Numeric (0 – 9) Hyphen (-) Ampersand (&) <p>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.</p> <p>The DBA Name field only allows the following characters:</p> <ul style="list-style-type: none"> Alpha (A – Z) Numeric (0 – 9) Hyphen (-) 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 .

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

| | [Help](#)

* 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 waiving any immunity to suit or liability including, without limitation, sovereign immunity, which may be available to the Department.

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.
- H. 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.
- J. 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.
- M. 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.
- N. That billings 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 **Electronic Signature PIN** 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.

[Or]

Our records indicate that an **Electronic Signature PIN** 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.

?

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 [Provider Enrollment Home](#). 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.

« Previous
Next »

Application Last Updated: 2009-11-22

Save Draft
Cancel Enrollment

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.

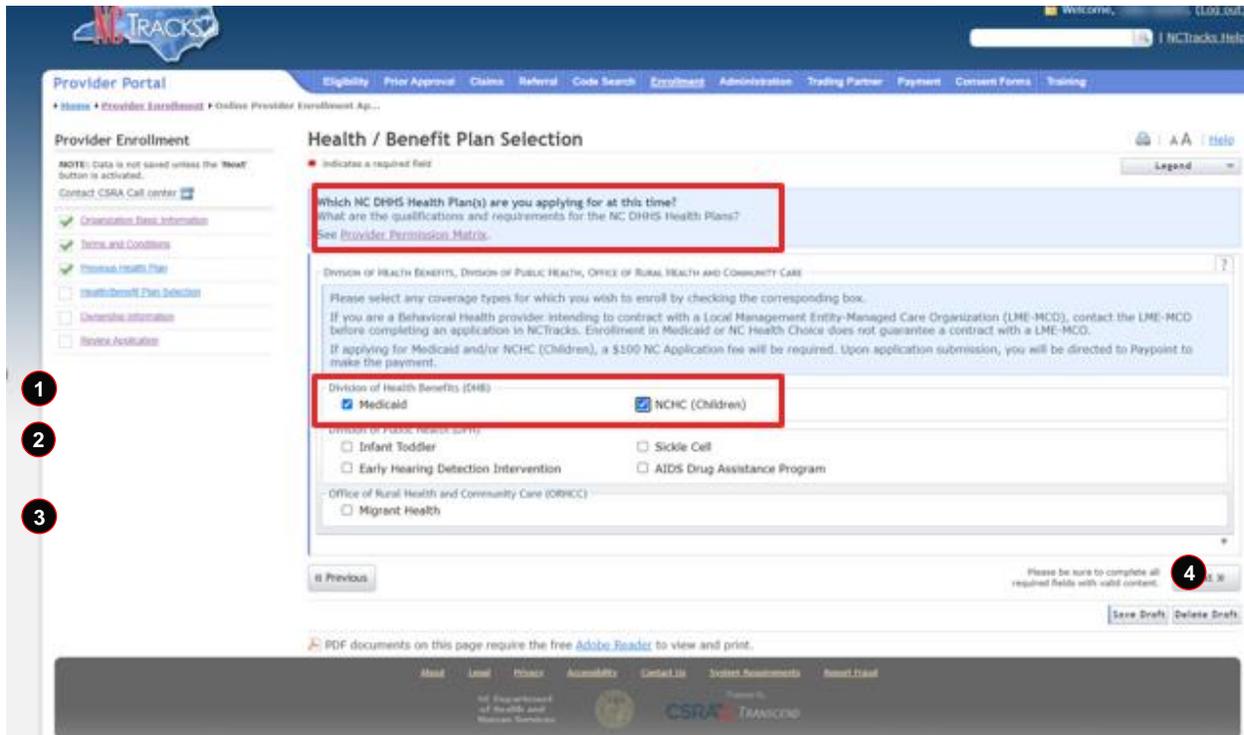


Exhibit 9. Health / Benefit Plan Selection Page

Step	Action
1	Do not opt out of coverage" under DHB. Division of Health Benefits (DHB): Medicaid and NCHC (Children) .
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): Migrant Health .
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: Medicaid and NCHC (Children) .

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.

Exhibit 10. Addresses Page #1

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

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 Yes or No . Note: 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.

Exhibit 12. Addresses Page #3

Step	Action
4	Service Locations: Do you have additional service locations? Select Yes or No . If Yes , enter Office Phone #, Address, City, State, and ZIP Code .
5	Select the Add button to add the service location.
6	Select the Next 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.

Taxonomy Classification Legend

* indicates a required field

Please select the Taxonomy Classification(s) under which you will be conducting business with NCTracks. All taxonomies selected should have been reported to the National Plan & Provider Enumeration System (NPPES) when you enumerated this NPI. If a submitted taxonomy has not been reported to NPPES, please report it within the next 30 days.

Taxonomy Classification

TYPE, CLASSIFICATION AND AREA OF SPECIALIZATION

Please select a Provider Type, Classification and Area of Specialization from the following drop-down lists that best describe the services you will be rendering. You may enter up to 15 Taxonomy Classifications.

Add Taxonomy Classification

Please complete all the required fields and click the **Add** button.

1 * Provider Type: OTHER SERVICE PROVIDERS

* Classification: Prevention Professional

* Area of Specialization: None

2

Add Clear

Taxonomy Classification Legend

* indicates a required field

Please select the Taxonomy Classification(s) under which you will be conducting business with NCTracks. All taxonomies selected should have been reported to the National Plan & Provider Enumeration System (NPPES) when you enumerated this NPI. If a submitted taxonomy has not been reported to NPPES, please report it within the next 30 days.

TYPE, CLASSIFICATION AND AREA OF SPECIALIZATION

Please select a Provider Type, Classification and Area of Specialization from the following drop-down lists that best describe the services you will be rendering. You may enter up to 15 Taxonomy Classifications.

Add Taxonomy Classification

Please complete all the required fields and click the **Add** button.

* Provider Type: AGENCIES

* Classification: Public Health or Welfare

* Area of Specialization: None

Add Clear

Exhibit 13. Taxonomy Classification Page

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

3.9 HSO SERVICES PAGE

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

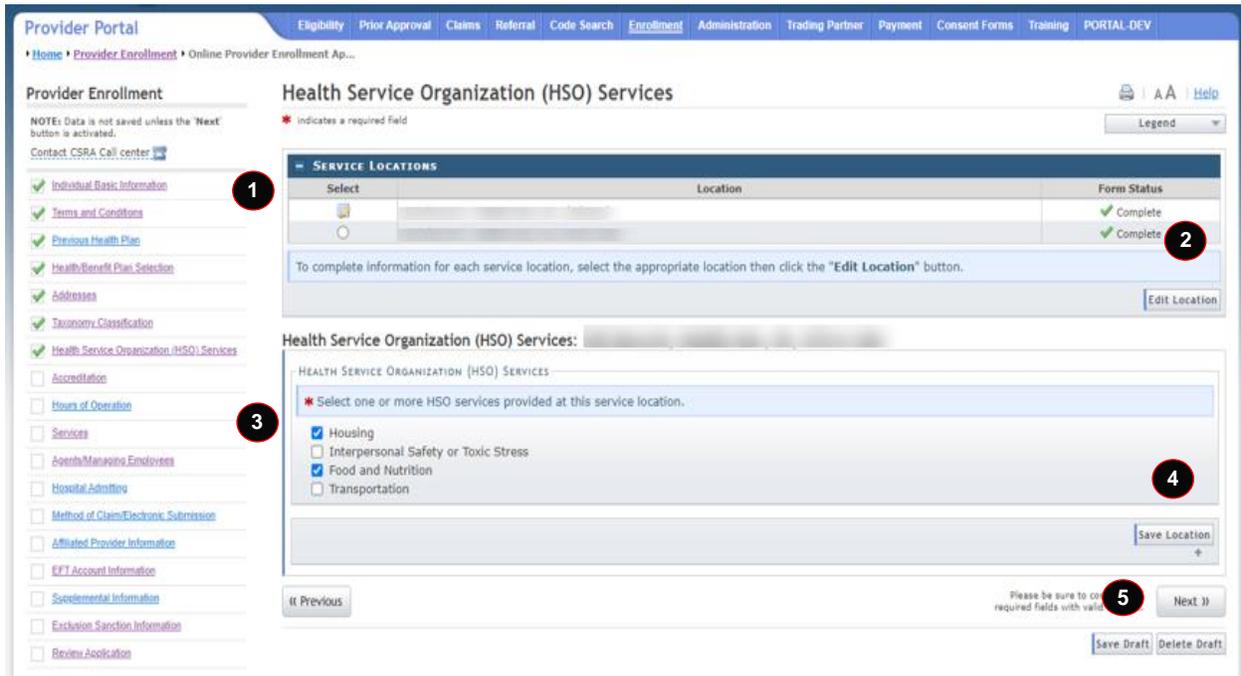


Exhibit 14. HSO Services Page

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: Housing, 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.

Exhibit 15. Accreditation Page #1

3.11 HOURS PAGE

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

Hours ?

1 * Does this facility operate 24/7?
 Yes No

Please indicate the hours each day a provider is available to see recipients at this location. Monday hours may be copied to the remaining weekdays by clicking the 'Copy' link. Totals will be calculated automatically.
Note: The total number of hours entered must be greater than zero.

PROVIDER HOURS OF OPERATION					
Day	From	to	From	to	Total
Monday Copy	8:00 AM	12:00 PM	-- Select --	-- Select --	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 (PCPs) must be available at each practice site a minimum of 30 hours per week. Your total number of office hours does not meet CCNC/CA participation guidelines. Please enter your reason for exception in the CCNC/CA Exception box. Approval for the exception is not a guarantee.

2 * Exception:

After-Hours Coverage ?

Note to CCNC/CA providers: The phone number will be the number that appears on a recipients Medicaid Identification (MID) card. Referring automatically to the Emergency Department or Hospital Switchboard is not acceptable.

3 * After-hours or 24/7 Responder Phone #: (919) 333-4444 ext.

4 * Type of after-hours or 24/7 responder coverage:

- Answering Service
- Phone message that gives number of provider
- Hospital operator who pages on-call provider
- Call forward or stay-on-line transferring
- Nurse Triage Service
- 24 hour hospital switchboard
- ER Triage
- Physician on call
- Other

5 * Describe 'Other':

Exhibit 17. Hours Page

Step	Action
1	Click the appropriate radio button beside Does this Facility operate 24/7? If No 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 Exception 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 Describe 'Other' box.

3.12 SERVICES PAGE

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

Services Legend

* indicates a required field

- 1 **INTERPRETATION SERVICES**
 - * Are Oral Interpretation Services available?
 - Yes No
 - * Is Braille supported?
 - Yes No
 - * Is Sign Language supported?
 - Yes No
- 2 **LANGUAGES SUPPORTED IN OFFICE**
 - * Languages:
 - Available Options:
 - 02 - Spanish
 - 03 - Arabic
 - 04 - Armenian
 - 05 - Burmese
 - 06 - Cambodian
 - 07 - Chinese
 - 08 - Creole
 - 09 - Croation
 - 10 - Farsi
 - 11 - French
 - 12 - French Creole
 - 13 - German
 - 14 - Greek
 - 15 - Hindi
 - 16 - Hmong
 - 17 - Italian
 - Selected Options:
 - 01 - English
- 3 **SPECIAL NEEDS**
 - Behaviorally Disruptive
 - Deaf/Hearing Impaired
 - Physically Handicapped
 - Blind/Visually Impaired
 - Intellectual and Development Disability
 - Sexually Aggressive
 - * Is this location TDD/TTY Equipped?
 - Yes No
 - * TDD/TTY Office Phone #: (000) 000-0000 ext.
- 4 **NEW PATIENTS ACCEPTED**
 - * Are you accepting new patients?
 - Yes No
 - * Do you accept siblings of established patients?
 - Yes No
- 5 **MEDICAID FOR PREGNANT WOMEN (MPW)**
 - I serve MPW patients only.
 - I serve both MPW and Medicaid patients.
 - I do not serve MPW patients.

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 Add button to add it to the Selected Options 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 Medicaid for Pregnant Women section. Note: 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.

1 Agents and Managing Employees

* indicates a required field

Legend

RELATIONSHIP DISCLOSURE

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, managing employee, director, board member, and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

* Does the applicant have any agent(s) and/or managing employee(s)?
 Yes No

Managing Relationships

Please add all managing relationships below.

MANAGING RELATIONSHIP - SMITH, JOHN

Last Name: **Smith** First Name: **John**
 Middle Name: [Redacted] Suffix: [Redacted]
 Date of Birth: [Redacted] SSN: [Redacted]
 Business Relationship: **Officer** Relationship to Another Disclosing Person: **Child**

I attest that I have entered the full legal name of the individual, and the individual does not have a middle name. **2**

[Edit] [Delete]

Add Relationship

Please complete all the required fields and click the **Add** button to save.

* Last Name: [Text Box] * First Name: [Text Box]
 Middle Name: [Text Box] (Enter your full middle name) Suffix: -- Select One --
 * Date of Birth: [mm/dd/yyyy] * SSN: 000-00-0000
 * Business Relationship: -- Select One -- * Relationship to Another Disclosing Person: -- Select One --

I attest that I have entered the full legal name of the individual, and the individual does not have a middle name.

[Add] [Clear] **4**

« Previous Please be sure to complete all required fields with valid content. Next »

[Save Draft] [Cancel Enrollment]

Exhibit 19. Agents and Managing Employees Page

Step	Action
1	Relationship Disclosure: Does the applicant have any agent(s) or managing employee(s)? Select Yes or No ; if Yes , the Managing Relationship section displays.
2	Select the Edit button to edit an existing Managing Relationship to change Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Email, Phone Number, and Business Relationship .
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.

Method of Claim and Electronic Transactions

Legend

* indicates a required field

* 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

« Previous

Please be sure to complete all required fields with valid content.

Next »

Save Draft Delete Draft

Exhibit 20. Method of Claim and Electronic Transactions

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

Print | AA | Help

* indicates a required field

Legend

1

ACCOUNT INFORMATION ?

* Routing Number:

* Account Number: * Account Number Confirmation:

* Account Type: -- Select One --

* Bank Name:

* Bank Address Line 1:

Bank Address Line 2:

* City:

* State: NORTH CAROLINA

* ZIP Code: 00000-0000

2

« Previous

Please be sure to complete all required fields with valid content.

Next »

Exhibit 21. EFT Account Information Page

Step	Action
1	Enter the account information.
2	Select the Next button.
	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.

3.16 EXCLUSION SANCTION INFORMATION PAGE

Exclusion Sanction Information Legend

* Indicates a required field

EXCLUSION SANCTION INFORMATION

The questions below must be answered for the enrolling provider, its owners, and agents* in accordance with 42 CFR 455.100; 101; 104; 106 and 42 CFR 1002.3.

- * An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This may include managing employees, general managers, business managers, office managers, administrators; Electronic Funds Transfer (EFT) authorized individuals, individual officers, directors, board members, etc.
- All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

For each question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.

* A. Has the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony, or entered into a pre-trial agreement for a felony?
 Yes No

Please add up to 5 Infraction/Conviction Dates.

INFRACTION/CONVICTION DATES	Infraction/Conviction Date
<input type="text" value="09/01/1999"/>	
<input type="text" value="mm/dd/yyyy"/>	

* B. Has the applicant, managing employees, owners, or agents ever had disciplinary action taken against any business or professional license held in this or any other state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?
 Yes No

* C. Has the applicant, managing employees, owners, or agent sever been denied enrollment, been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state; or ever been directly or indirectly affiliated with a provider or supplier that has been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health insurance program in any state?
 Yes No

* D. Has the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state; or ever been directly or indirectly affiliated with a provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state?
 Yes No

* E. Has the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal Agency or Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?
 Yes No

* F. Does the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid; or ever been directly or indirectly affiliated with a provider or supplier that has uncollected debt owed to Medicare, Medicaid, or CHIP?
 Yes No

* G. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?
 Yes No

* H. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?
 Yes No

* I. Has the applicant, managing employees, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?
 Yes No

* J. Has the applicant, managing employees, owners, or agent sever been found to have violated federal or state laws, rules, or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any publicly funded federal or state health care or health insurance program and been sanctioned accordingly; or ever been directly or indirectly affiliated with a provider or supplier that had its Medicare, Medicaid, or CHIP billing privileges denied or revoked?
 Yes No

* K. Has the applicant, managing employees, owners, or agents ever been convicted of an offense against the law other than a minor traffic violation?
 Yes No

Please be sure to complete all required fields with valid content.

Exhibit 22. Exclusion Sanction Information Page

Page

Step	Action
1	<p>Select Yes or No for each Exclusion Sanction question. When Yes is selected for a question, the Infraction/Conviction Dates section displays. Select the Add button to add an Infraction/Conviction Date.</p> <p>For each question answered Yes, 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.</p> <p>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).</p> <p>Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p>

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.

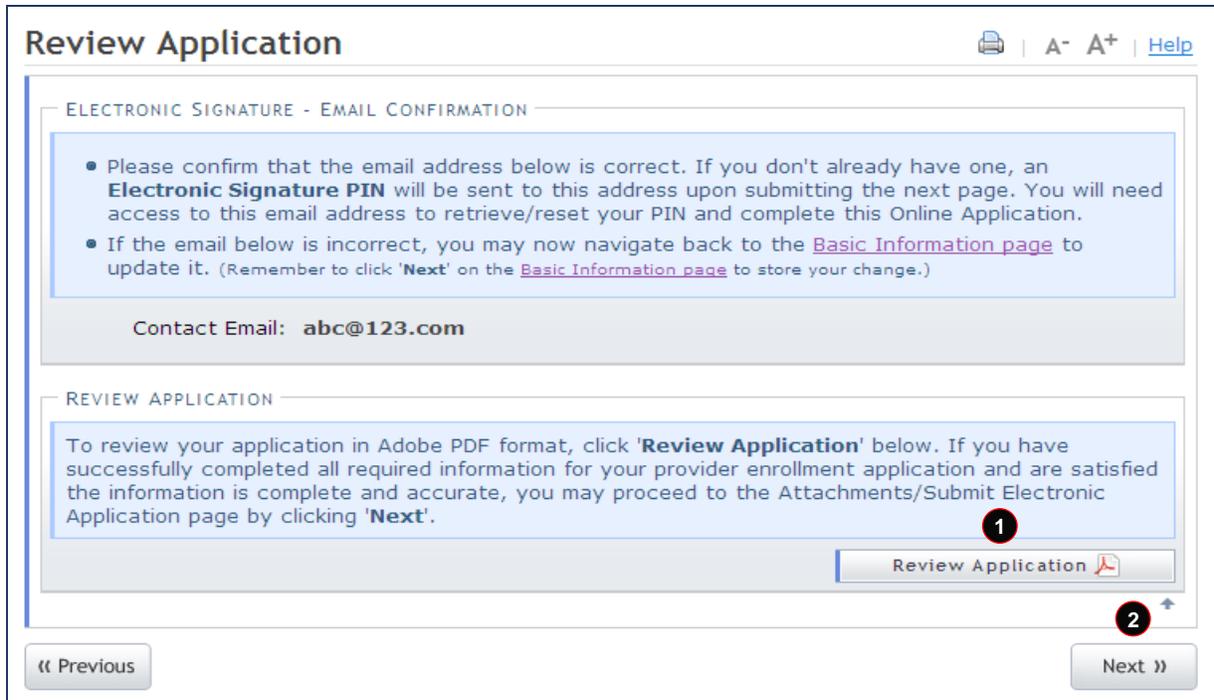


Exhibit 23. Review Application Page

Step	Action
1	Select the Review Application button.
2	Select the Next button to continue.

3.18 APPLICATION SAVED PAGE

This page displays when the application is saved.

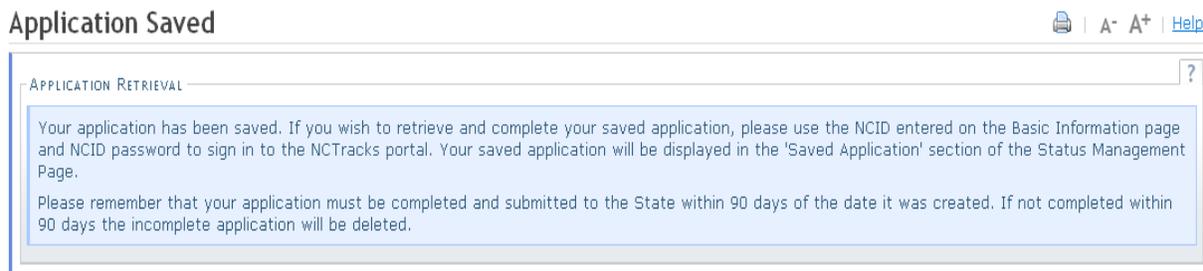


Exhibit 24. Application Saved Page

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

Print | A A | Help

Legend

1 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 application documents.

2 APPLICATION FEE REQUIRED

Thank you for applying to Medicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC Application Fee is required. Please click the 'Pay Now' button. You will be directed to Paypoint to make the payment. [Pay Now](#)

3 FINGERPRINTING REQUIRED

In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application you submitted requires fingerprinting. After your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions for completing the fingerprinting process. See [Fingerprinting Information Page](#) for more information.

4 REQUIRED ATTACHMENTS

Your application indicates that you are enrolling as:

- PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health

The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail.

- No Required Attachments for the Taxonomy

5 ELECTRONIC ATTACHMENTS

If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic attachments on the Status Management Page. [Upload Documents](#)

[Return to Provider Enrollment Status and Management Home](#)

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 Online Application and/or Cover Sheet . This will be the only opportunity to save, download, or print the PDFs.
2	Select the Pay Now button. The PayPoint landing page displays. See Addendum B to view the PayPoint process. Note: 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 Upload Documents 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.

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