

## JOB AID Re-verification

### OVERVIEW

This Job Aid provides foundational information on the purpose and requirements for provider re-verification and guides the user through the steps for completing the re-verification process through NCTracks.

### RE-VERIFICATION PURPOSE

The re-verification process ensures the provider record is accurate and allows a criminal background check for all owners and managing relationships associated with the provider record.

The Code of Federal Regulations, Title 42, Part 455.414 requires the state Medicaid agency to re-validate the enrollment of all providers regardless of the provider type at least every 5 years. Therefore, NC Medicaid providers are required to complete the re-verification process every 5 years.

In addition to the criminal background check, a set of fingerprints may be required from each individual provider and any owner that has a 5% or more direct or indirect ownership in the provider/entity. Fingerprint requirements are based on the provider type risk level. Only the individual provider and owners with 5% or more ownership for certain high-risk provider types will be required to upload fingerprint information.

A site visit by Public Consulting Group (PCG) may also be required.

### RE-VERIFICATION FEES

- A \$100 North Carolina application fee is required from individual providers (waived through June, 2023).
- A \$100 North Carolina application fee is also required from Organizations and Atypical Organizations if active in Medicaid.
- The Federal Fee will be required per location when one or more Moderate or High Risk taxonomy codes are active. (Please refer to the Provider Permission Matrix [PPM].)
- The Federal Fee changes from year to year. The federal fee can be found under Quick Links on the [Provider Enrollment home page](#) by clicking on the link entitled "Federal Fees & NC Enrollment Fees by Year."

**Note:** Effective Jan. 9, 2022, NCTracks no longer requires Medicaid providers to pay the \$100 NC application fee with enrollment and re-verification applications, pursuant to NC Senate Bill 105 Session Law 2021-180 Section 9D.9(a), which waives the fee until June 30, 2023. The NC application fee is non-refundable if your application is denied.

In the event that the enrolling provider type requires fingerprinting, NCTracks will not require any additional fees. However, the local fingerprinting agency may require a fee for their service. It is recommended that the agency be contacted to confirm.

### WHO MUST COMPLETE RE-VERIFICATION?

Actively enrolled individual, organization, and atypical organization providers are required to complete the re-verification application.

**Note:** The Office Administrator (OA) or the Enrollment Specialist (ES) for the provider can complete the re-verification process. However, the OA is the only person who can submit the re-verification application.

## RE-VERIFICATION EXCEPTIONS

Exceptions for providers who do not need to complete re-verification are:

- Providers enrolled with a Division of Mental Health (DMH) only health plan.
- Providers who are time-limited enrolled such as out-of-state (OOS) Lite providers.
- Be aware that OOS Lite providers must continue to complete the enrollment process every 365 days.
- Providers with an active 302R00000X Health Maintenance Organization or 305R00000X Preferred Provider Organization taxonomy code.
- Newly enrolled providers do not need to complete re-verification for 5 years.

## RE-VERIFICATION LETTER

When a provider is due to complete a re-verification application, a Re-verification Letter will be sent to the provider's NCTracks Message Center Inbox 70 days before the due date. The Re-verification Letter instructs the provider to navigate to their **Status and Management** page and electronically complete and submit the re-verification application.

If a re-verification application is not submitted, reminder letters will be sent to the provider's Message Center Inbox at 50 days, 20 days, and 5 days prior to the provider's re-verification due date.

[Current Date]  
 [Correspondence Provider Address Line 1]  
 [Provider Address Line 2]  
 [Provider Address City], [Provider Address State] [Provider Address Postal Code]

NPI/Atypical Provider ID: XXXXXXXXXX  
 Provider Name: XXX

Dear [Salutation],

We are verifying and updating North Carolina DHHS provider enrollment records for NPI/Atypical Number XXXXXXXXXX. It is important that you submit the Re-verification Application on or before MM/DD/YYYY to avoid suspension and/or termination of your NPI/Atypical ID. If you serve Carolina ACCESS or ACCESS II enrollees, they will be reassigned if your NPI/Atypical ID is terminated.

As outlined in your North Carolina DHHS Provider Administrative Participation Agreement, you must keep your provider information (ownership, licensure, affiliations, address, contact information) updated.

As part of Re-verification, you will be required to review your entire provider record Office Administrator should follow these steps to complete the re-verification application:

1. Login to the NCTracks Secure Provider Portal (<http://www.nctracks.nc.gov>)
2. Navigate to the Status and Management Page
3. Your NPI/Atypical ID will be located in the Re-verification Section
4. Select the NPI/Atypical ID and click Re-verify
5. Complete and submit the Re-verification Application

MORE INFORMATION

- Please visit the NCTracks website (<http://www.nctracks.gov>) for more information about the DHHS Programs, Claims, CCNC/CA, and other provider information.

If you have any questions regarding this notice or need additional assistance, please contact the CSRA Call Center at 800-688-6696 or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

Sincerely,  
 NCTracks Operations Center

## SUSPENSION LETTER

If the re-verification application is NOT submitted 70 days prior to the due date indicated on the initial re-verification notification letter, the provider’s NC Medicaid, Division of Public Health (DPH), and Office of Rural Health (ORH)/Migrant Health health plans will be suspended for 50 days.

A Re-verification Suspension Letter will be sent to the provider’s Message Center Inbox. A hardcopy of the letter will also be sent by regular U.S. postal mail.

The provider’s claims will pend if their record is suspended.

Claims will continue to pend until the re-verification application is submitted by the provider.

[Current Date]  
 [Correspondence Provider Address Line 1]  
 [Provider Address Line 2]  
 [Provider Address City], [Provider Address State] [Provider Address Postal Code]

NPI/Atypical Provider ID: XXXXXXXXXXXX  
 Provider Name: XXX

Dear [Salutation],

Our record indicates that you have not submitted a Re-verification Application.

Your claims are now suspended.

To continue participation in the North Carolina DHHS programs, you must complete the Re-verification Application by MM/DD/YYYY. If you submit your Re-verification Application by MM/DD/YYYY, your suspended claims will be released for processing.

Your Office Administrator should follow these steps to complete the re-verification application:

1. Login to the NCTracks Secure Provider Portal (<http://www.nctracks.nc.gov>)
2. Navigate to the Status and Management Page
3. Your NPI/Atypical ID will be located in the Re-verification Section
4. Select the NPI/Atypical ID and click Re-verify
5. Complete and submit the Re-verification Application

**IF THIS REQUEST IS NOT COMPLETED BY MM/DD/YYYY, YOUR NPI/ATYPICAL ID WILL BE TERMINATED AND A RE-ENROLLMENT WILL BE REQUIRED TO PARTICIPATE IN THE DHHS PROGRAMS.**

If you have any questions regarding this notice or need additional assistance, please contact the CSRA Call Center at 800-688-6696 or [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

## TERMINATION LETTER

The provider will be terminated from the NC Medicaid, DPH, and ORH/Migrant Health health plans following 50 days of suspension.

An automated process will release “Pended” claims with dates of service prior to the re-verification due date to continue to adjudicate. “Pended” claims submitted with dates of service during the suspension period will release and deny.

CERTIFIED MAIL

[Current Date]

[Correspondence Provider Address Line 1]  
[Provider Address Line 2]  
[Provider Address City], [Provider Address State] [Provider Address Postal Code]

NPI/Atypical Provider ID: [Provider National Provider Identifier][Provider Atypical]  
Provider Name: [Provider Name]

Re: DHHS Health Plan Termination

Dear Provider Name,

Your participation in the following DHHS health plan has been terminated:

Health Plan: [Health Plan Identifier]  
Health Plan: [Health Plan Identifier]  
Health Plan: [Health Plan Identifier]  
Health Plan: [Health Plan Identifier]  
Health Plan: [Health Plan Identifier]  
Health Plan: [Health Plan Identifier]

## SUPPORTING DOCUMENTATION REQUIRED

If during the credentialing process 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 given an additional 10 days to submit the required information. If the information is received and reviewed, but it is still deemed inadequate, the provider will be given an additional 10 days. If the correct information is not received the third time, the application will be abandoned. If no documentation is received after the first 30-day notice or either of the 10-day notices, the application will be abandoned.

Date:  
NPI/Atypical Id:  
Provider Name:  
Reference Id:

Dear

Your application for DHHS participation submitted on [REDACTED] is incomplete as submitted and cannot be processed for approval. Please submit the following required document(s) by [REDACTED]:

Required Documents:  
[REDACTED]

An electronic copy of the required documentation must be uploaded on the Provider Secure Portal Status and Management Page. Emailed, faxed or mailed documentation will not be accepted.

If you do not submit the required documents by [REDACTED], your application will be abandoned. If you have already passed your Re-verification Due Date, your health plans will be terminated and you will be required to re-enroll. If you have not already passed your re-verification Due Date, you must complete and submit a new Re-verification application and pay any applicable fees.

If you have any questions regarding this notice or need additional assistance, please contact the NCTracks Operations Center at [1-800-688-6696](tel:1-800-688-6696) or email the NCTracks Operations Center at [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com).

Sincerely,  
NCTracks Operations Center

Abandoned re-verification applications will result in the termination of the provider's Medicaid, DPH, and ORH/Migrant Health health plans if the current date is after the suspension date. If Medicaid, DPH, and ORH/Migrant Health are the only active health plans on the provider's record, a Re-enrollment application will be required. If the current date is before the suspension date, the provider can resubmit the re-verification application.

Subject: Abandoned Application

Date: MM/DD/YYYY  
 NPI/Atypical ID: XXXXXXXXXXXX  
 Provider Name: XXXXXXXXXXXXXXXXXXXX  
 Reference ID: XXXXXXXXXXXXXXXX

Dear XXXXX,

Your application submitted on MM/DD/YYYY has been abandoned because you did not submit the required documentation within 30/10 days.

If you have already passed your Re-verification Due Date, your health plans will be terminated and you will be required to re-enroll. If you have not already passed your Re-verification Due Date, you must complete and submit a new Re-verification application and pay any applicable fees.

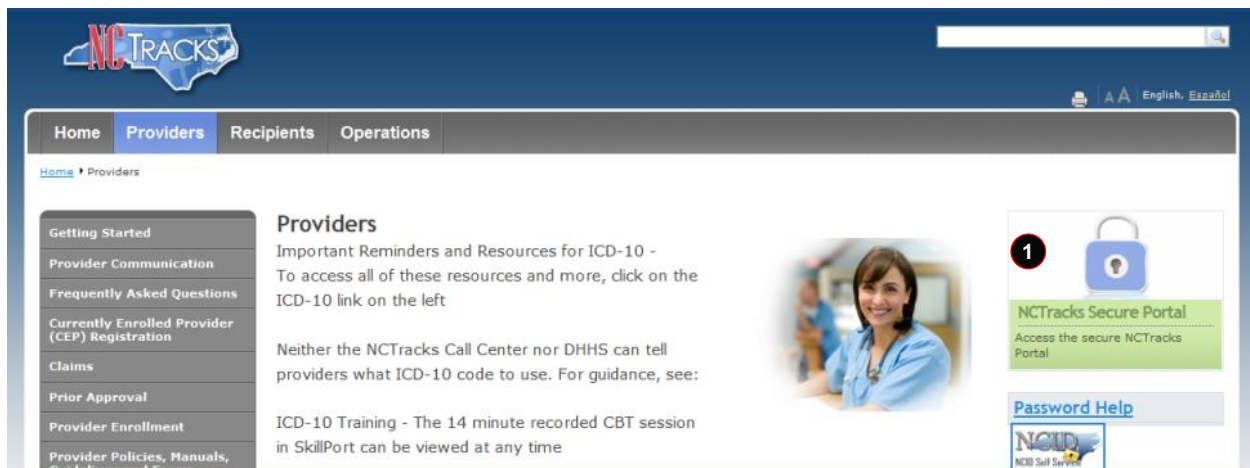
If you have any questions regarding this notice or need additional assistance, please contact the NCTracks Operations Center 800-688-6696 or email the NCTracks Operations Center at [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com)

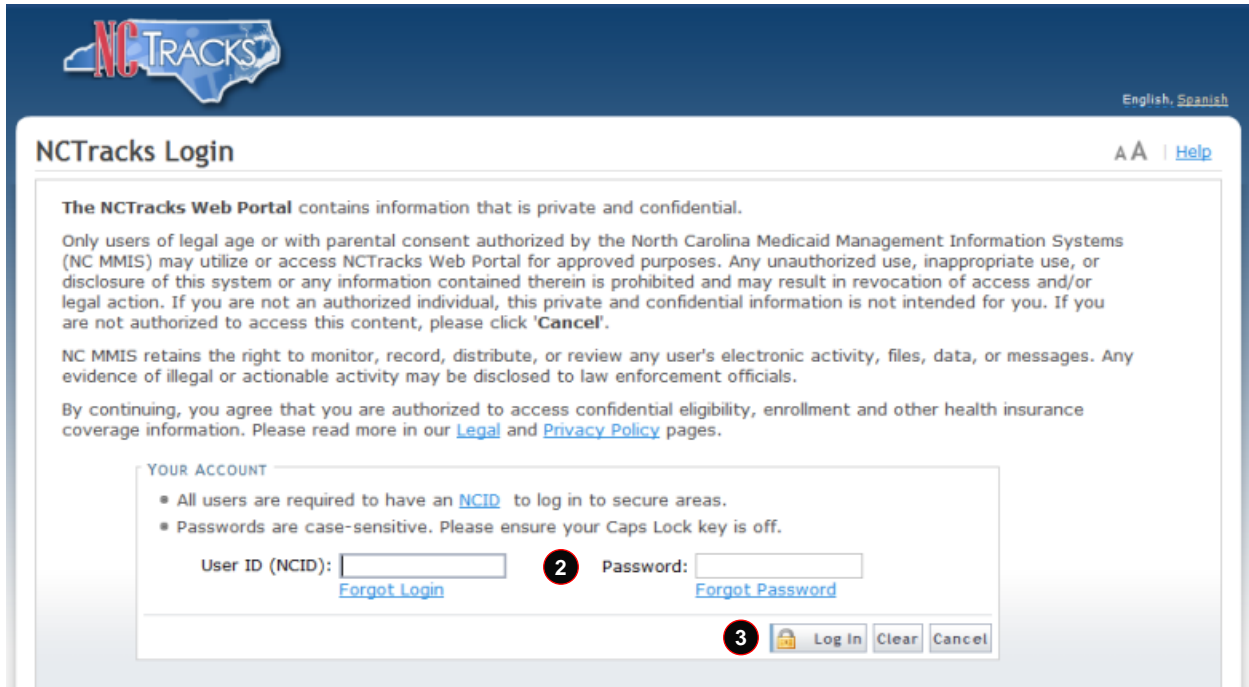
Sincerely,

NCTracks Operation Center

**Note:** The OA/ES user will have access to the notification letters via the Message Center Inbox, as well as be provided a hyperlink on the **Status and Management** page to view the notification.

### LOG IN TO NCTRACKS PROVIDER PORTAL





Step	Action
1	<p>Open the latest version of a supported Internet browser, such as Microsoft Edge, Mozilla Firefox, or Google Chrome.</p> <p>Enter the following web address:  <a href="https://www.nctracks.nc.gov/content/public/providers.html">https://www.nctracks.nc.gov/content/public/providers.html</a></p> <p>NCTracks will open in the <b>Providers</b> tab. Select <b>NCTracks Secure Portal</b>.</p>
2	<p>Enter your NCID as your User ID; then enter your Password.</p> <p><b>Note:</b> If you do not have an NCID, you may sign up for one by selecting the <b>NCID</b> link on this page.</p>
3	<p>Select <b>Log In</b>.</p>

**Note:** 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, refer to the “Provider Multi Factor Authentication Registration Process” Job Aid located in SkillPort.

The NCTracks **Provider Portal Home** page displays.

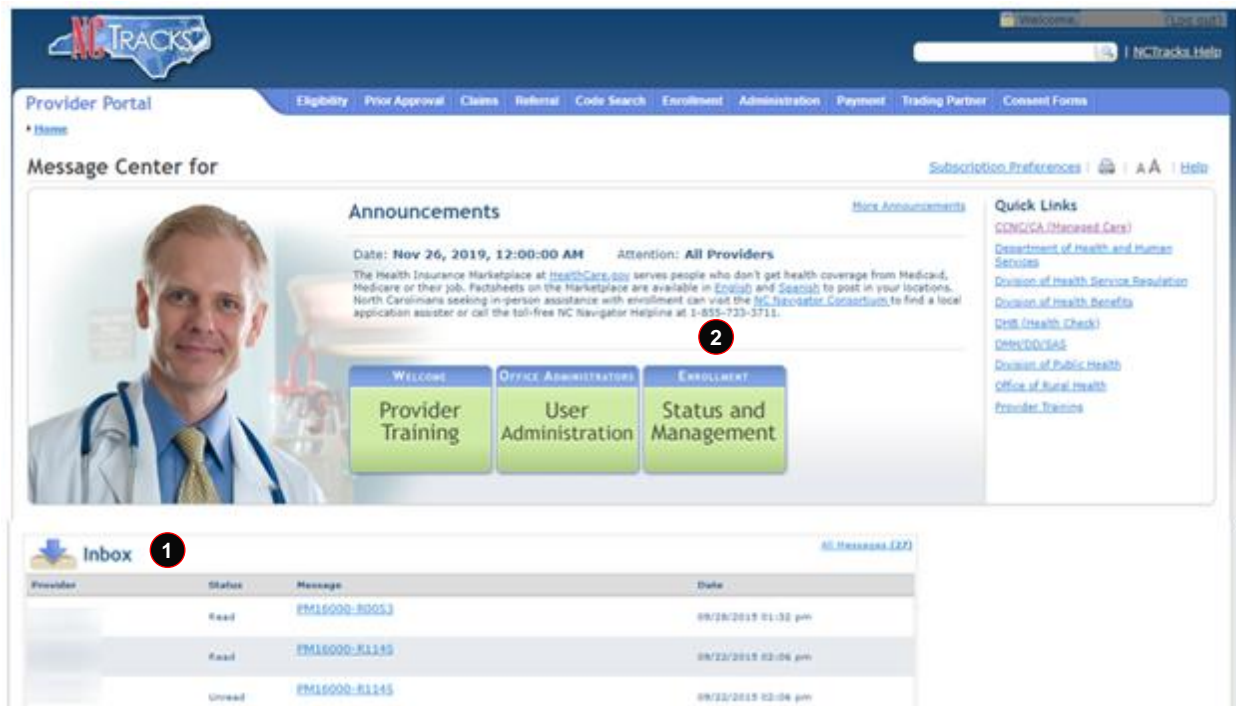


## COMPLETE THE RE-VERIFICATION PROCESS

### Provider Portal Home Page

The step-by-step re-verification process is completed from the **Status and Management** section of the NCTracks Provider Portal.

**Note:** The OA or someone who has been designated as the ES for the provider can complete re-verification. However, the OA is the only person who can submit the re-verification application.

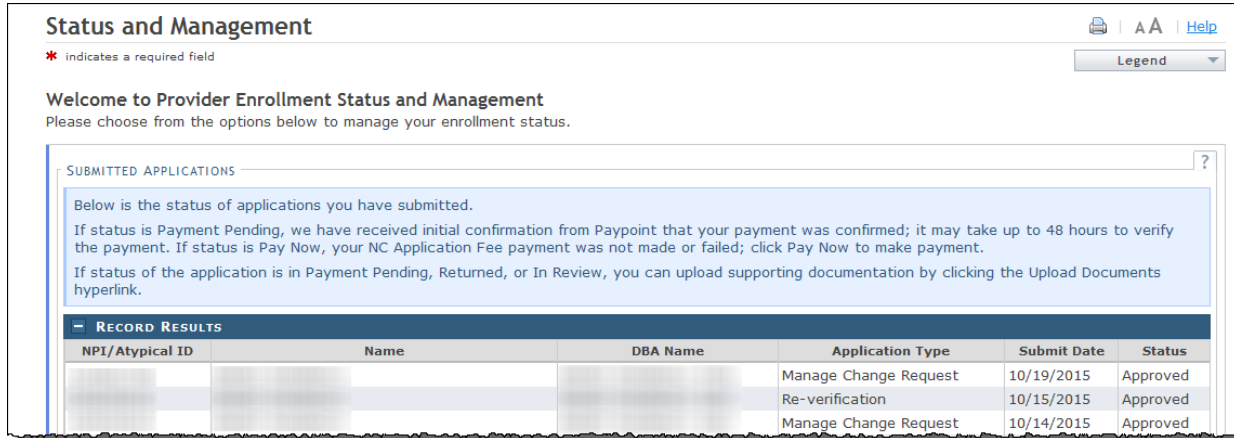


Step	Action
1	A Re-verification Letter is sent to the provider's NCTracks Inbox, alerting the provider that they need to complete the re-verification application.
2	Select <b>Status and Management</b> .

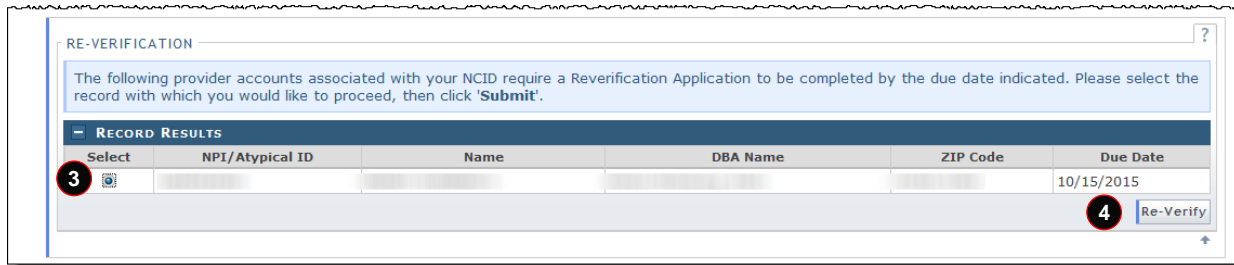
The **Status and Management** page displays.

## Status and Management Page

The **Status and Management** page allows the provider to manage their enrollment for the application process. Here you will find sections for Submitted Applications, Saved Applications, Manage Change Request, and Re-verification. Scroll down to the **Re-verification** section of the page.



The **Re-verification** section displays all National Provider Identifiers (NPIs) and Atypical IDs that are due for re-verification under that particular OA.



Step	Action
3	Select the line with the desired NPI.
4	Select <b>Re-Verify</b> .

The **Re-Verification Application – Organization Basic Information** or **Re-Verification Application – Individual Basic Information** page displays.

This page presents specific information about you as an Organization or Individual provider. This information must match what is reported on your income tax return.

Re-Verification Application - Organization Basic Information

\* Indicates a required field

Legend

IDENTIFYING INFORMATION

\* Organization Name:

\* EIN: 00-0000000

\* Email:

\* NPI: 0000000000

\* Month of Fiscal Year End: -- Select One --

DOING BUSINESS AS (DBA)

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

DBA Information

\* DBA Name:

\* Years Doing Business Under

This Name:

OWNERSHIP INFORMATION

\* Business Type: CORPORATION

The Business Type entered on this application matches what was reported to the provider's state business registration entity.

REGISTERING WITH NC SECRETARY OF STATE

\* Are you required by law to register with NC Secretary of State?  
 Yes  No

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): -- Select One --

\* Last Name:

Middle Name:   
 (Enter your full middle name)

\* Contact Email:

\* Office Phone #: (000) 000-0000 ext.

\* First Name:

Suffix: -- Select One --

\* SSN:

\* Office Fax #: (000) 000-0000

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

\* Is this contact person an Owner or Managing Employee?  
 Owner  Managing Employee

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: mm/dd/yyyy

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 >>

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Step	Action
5	Select the <b>Attestation</b> checkbox and select <b>Next</b> .  Note: The Business Type entered on this application must match what was reported to the provider's state business registration entity.

Re-Verification Application - Individual Basic Information

\* indicates a required field

Legend

\* indicates a required field

Legend

IDENTIFYING INFORMATION

Last Name: [Redacted] First Name: [Redacted]  
 Middle Name: [Redacted] Suffix: [Redacted]  
 Date of Birth: [Redacted] SSN: [Redacted]  
 Gender: F NPI/Atypical Provider ID: [Redacted]  
 \* Email: [Redacted]

EMPLOYER IDENTIFICATION NUMBER (EIN)

\* Will your income be reported to an EIN?  
 Yes  No

OWNERSHIP INFORMATION

\* Business Type: SELF (INDIVIDUAL FILING UNDER A SSN)

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): [Redacted] \* First Name: [Redacted]  
 \* Last Name: [Redacted] Middle Name: [Redacted] Suffix: -- Select One --  
 (Enter your full middle name)  
 \* Contact Email: [Redacted] SSN: [Redacted]  
 \* Office Phone #: [Redacted] t. [Redacted] Office Fax #: [Redacted]

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

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Step	Action
6	Review the information on the page and select <b>Next</b> .

The Re-Verification Application – Terms and Conditions page displays.

Re-Verification Application - Terms and Conditions

\* indicates a required field

Legend

**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

Step	Action
7	Read the <b>Terms and Conditions</b> page as you scroll down the page.
8	Select the <b>Attestation</b> checkbox and select <b>Next</b> .

Review all pages of the application and update your provider information as necessary. Your enrollment type determines which pages must be reviewed; the pages will present as if you are completing a Manage Change Request application.

### Individual OPR Lite Provider

1. Individual Basic Information page
2. Terms and Conditions page (OPR Lite Specific Agreement)
3. Basic Information Completed page
4. Health Plan Selection page
5. Addresses page
6. Taxonomy Classification page
7. Accreditation page
8. Agents and Managing Relationships page
9. Provider Supplemental Information page
10. Exclusion Sanction Information page
11. Federal Requirements page (see PPM)
12. Sign and Submit page
13. Final Steps page

### Individual Full Provider

1. Individual Basic Information page
2. Terms and Conditions page
3. Basic Information Completed page
4. Health Plan Selection page
5. Name and Address page
6. Taxonomy Classification page
7. Add Services and Endorsements page (see PPM)
8. Prior Approval (PA) Information page (N/A for OOS providers)

9. Accreditation page
10. Community Care of North Carolina/Carolina ACCESS page (N/A for rendering only providers; displayed for Medicaid providers; see PPM)
11. Physician Extenders Participation page (dependent on Taxonomy Classification page)
12. Preventive and Ancillary Services page (displayed for CCNC/CA providers)
13. Hours page (N/A for OOS providers)
14. Services page (N/A for OOS providers)
15. Agents and Managing Employees page
16. Pharmacy Information page (see PPM)
17. Hospital Admitting page (N/A for OOS providers)
18. Method of Claim and Electronic Submission page (N/A for rendering only providers)
19. Associate Billing Agent page (N/A for rendering only providers; dependent on Method of Claim and Electronic Submission page)
20. Affiliated Provider Information page
21. EFT Account Information page (N/A for rendering only providers)
22. NC Minority Provider (NCMP) Information
23. Provider Supplemental Information page
24. Exclusion Sanction Information page
25. Trading Partner Information page (N/A for rendering only providers; dependent on Method of Claim and Electronic Submission page)
26. Federal Requirements page (see PPM)
27. Sign and Submit page
28. Final Steps page

### **Organization Full Provider**

1. Organization Basic Information page
2. Terms and Conditions page
3. Basic Information Completed page
4. Health Plan Selection page
5. Ownership Information page (displayed if business type is 1-Corporation, 5-Non-Profit, 6-Partnership, or C-LLC)
6. Addresses page
7. Taxonomy Classification page
8. Add Services and Endorsements page (see PPM)
9. Prior Approval (PA) Information page (N/A for OOS providers)
10. Accreditation page

11. Community Care of North Carolina/Carolina ACCESS page (displayed for Medicaid providers; see PPM)
12. Physician Extenders Participation page (see PPM)
13. Preventive and Ancillary Services page (displayed for CCNC/CA providers)
14. Hours page (N/A for OOS providers)
15. Services page (N/A for OOS providers)
16. Agents and Managing Employees page
17. Pharmacy Information page (see PPM)
18. Facilities Information page (see PPM)
19. Method of Claim and Electronic Submission page
20. Associate Billing Agent page (N/A for rendering only providers; dependent on Method of Claim and Electronic Submission page)
21. EFT Account Information page
22. NC Minority Provider (NCMP) Information
23. Exclusion Sanction Information page
24. Trading Partner Information page (dependent on Method of Claim and Electronic Submission page)
25. Federal Requirements page (see PPM)
26. Sign and Submit page
27. Final Steps page

### **Atypical Organization Full Provider**

1. Organization Basic Information page
2. Terms and Conditions page
3. Basic Information Completed page
4. Health Plan Selection page
5. Ownership Information page (displayed if business type is 1-Corporation, 5-Non-Profit, 6-Partnership, or C-LLC, or OA is Owner)
6. Addresses page
7. Taxonomy Classification page
8. Add Services and Endorsements page (see PPM)
9. Accreditation page
10. Hours page (N/A for OOS providers)
11. Services page (N/A for OOS providers)
12. Agents and Managing Employees page
13. Method of Claim and Electronic Submission page

- 14. Associate Billing Agent page (dependent on Method of Claim and Electronic Submission page)
- 15. EFT Account Information page
- 16. Exclusion Sanction Information page
- 17. Trading Partner Information page (dependent on Method of Claim and Electronic Submission page)
- 18. Federal Requirements page (see PPM)
- 19. Sign and Submit page
- 20. Final Steps page

**Note:** This Job Aid does not contain all of the pages that may display as part of the re-verification application. Key pages that differ from those for a Manage Change Request application are highlighted below.

Step	Action
9	Owners with 5% or more ownership select the <b>Attestation</b> checkbox. The enrolling provider entered on this application must match what was reported to the provider's state business registration entity, licensure board, and Medicare.



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**

Managing Relationships

Please add all managing relationships below.

**10** + **MANAGING RELATIONSHIP** - (AUTHORIZED INDIVIDUAL MANAGING CONTACT) --- NEWLY ADDED

Add Relationship

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

\* Last Name:  \* First Name:   
 Middle Name:  Suffix: -- Select One --  
 (Enter your full middle name)  
 \* Date of Birth: mm/dd/yyyy \* SSN:   
 \* Email:  \* Phone Number:   
 \* Business Relationship: -- Select One --

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

\* Address Line 1:   
 Address Line 2:   
 \* City:   
 \* State: --  
 \* ZIP Code:

**11** Verify Address  
**12** Add Clear

Step	Action
10	Selecting the plus sign “+” beside <b>Managing Relationship</b> will allow you to edit by adding missing information or end-dating the individual if they no longer hold the role.
11	Once all changes are made, select the <b>Verify Address</b> button.
12	Select the <b>Add</b> button.
13	Once all information is correct, select the <b>Next</b> button.

The **NC Minority Provider (NCMP) Information** page will display to ask the provider if they are an NC Minority Provider. An NC Minority Provider is owned/controlled and managed by at least 51% racial/ethnic minorities, women, people with disabilities, people who are LGBTQ veterans, and/or otherwise socially and economically disadvantaged as defined in 15 U.S.C.

**NC Minority Provider (NCMP) Information**

\* indicates a required field

Legend

NC MINORITY PROVIDER QUESTIONS

\* 1. A NC Minority Provider (NCMP) is owned/controlled and managed by at least fifty-one percent (51%) racial/ethnic minorities, women, people with disabilities, people who are LGBTQ+, veterans and/or otherwise socially and economically disadvantaged as defined in 15 U.S.C. § 637. Is the provider a NCMP?

Yes  
 No  
 Choose not to disclose

\* 2. If the provider is a NCMP, does the provider permit NC DHHS to report provider's NCMP status at the provider level (for instance, on an interactive map to help consumers identify providers who may share lived experience)?

Yes  
 No

\* 3. Is the provider certified with the North Carolina Historically Underutilized Business Office? (See <https://ncadmin.nc.gov/businesses/hub>)

Yes  
 No/Not applicable

NC MINORITY PROVIDER INFORMATION DETAILS

NC MINORITY PROVIDER GROUP INFO DETAILS			
SSN	Name	Group that Owns the NCMP	Type of Racial/Ethnic Minority
		RACIAL/ETHNIC MINORITY , WOMAN , VETERAN	AMERICAN INDIAN/NATIVE AMERICAN/ALASKA NATIVE
***_**_		WOMAN , VETERAN	
***_**_		WOMAN , SOCIALY/ECONOMICALLY DISADVANTAGED	

The drop-down contains all managing employees and owners listed on the application along with last 4 digits of the individual's SSN. Please select any individual for whom you are adding NCMP characteristics.

\* Select Individual: -- Select One --

Previous Next

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

14a

14b

Step	Action
14a	Answer YES or NO for each Minority Provider Question.
14b	If YES is selected, choose the appropriate individual in the drop-down menu.

The **Provider Supplemental Information** page is required for Individual providers to add and/or edit the provider's work history, education, and current malpractice insurance information. This information was collected at initial enrollment and re-enrollment for individual providers beginning August 9, 2020. If NCTracks has data on file, your data will be pre-populated for you to review and edit if necessary.

### Re-Verification Application - Provider Supplemental Information

Legend

\* indicates a required field

#### WORK HISTORY

Enter your work history as a health professional for the past 5 years. Work history prior to 5 years ago is not needed. If there is a gap in your employment of more than six months, please upload documentation clarifying the gap upon application submission.

01/01/2020 - 12/31/9999

+ , 01/01/2015 - 12/31/2019

Add Work History

\* Company Name:  \* Job Title:

\* Start Date:  \* End Date:

Add

#### EDUCATION

Enter your highest level of education completed.

+ , 08/15/2000 - 12/15/2014

Add Education History

\* School Name:  \* Degree:

\* Start Date:  \* Graduate Date:

Add

#### CURRENT MALPRACTICE INSURANCE COVERAGE

Medical providers should carry professional liability coverage, often called malpractice insurance. This insurance covers your exposure to liability arising from your profession, including allegations of malpractice. Liability insurance offers essential financial protection because a malpractice suit can be brought against you at any time after you have seen a patient.

Enter your current malpractice insurance coverage.

\* Do you have malpractice insurance or are you covered under a federal tort?

Yes  No

+ FEDERAL TORT MALPRACTICE, 01/01/2021 - 12/31/2025

Add Malpractice

\* Malpractice type: -- Select One --

\* Effective Date:  \* Expiration Date:

Add

« Previous Next »

Save Draft Delete Draft

### Provider Supplemental Information

Legend

\* indicates a required field

15

#### WORK HISTORY

Enter your work history as a health professional for the past 5 years. Work history prior to 5 years ago is not needed. If there is a gap in your employment of more than six months, please upload documentation clarifying the gap upon application submission.

##### Add Work History

\* Company Name:  \* Job Title:   
 \* Start Date:  \* End Date:

Add

16

#### EDUCATION

Enter your highest level of education completed.

##### Add Education History

\* School Name:  \* Degree:   
 \* Start Date:  \* Graduate Date:

Add

17

#### CURRENT MALPRACTICE INSURANCE COVERAGE

Medical providers should carry professional liability coverage, often called malpractice insurance. This insurance covers your exposure to liability arising from your profession, including allegations of malpractice. Liability insurance offers essential financial protection because a malpractice suit can be brought against you at any time after you have seen a patient.

Enter your current malpractice insurance coverage. Upon submission of the application, upload a copy of the insurance face sheet from the malpractice carrier or a copy of the federal tortletter or an attestation from the practitioner of federal tort coverage.

\* Do you have malpractice insurance or are you covered under a federal tort?  
 Yes  No

18

Previous

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

Next

Save Draft Delete Draft

#### CURRENT MALPRACTICE INSURANCE COVERAGE

Medical providers should carry professional liability coverage, often called malpractice insurance. This insurance covers your exposure to liability arising from your profession, including allegations of malpractice. Liability insurance offers essential financial protection because a malpractice suit can be brought against you at any time after you have seen a patient.

Enter your current malpractice insurance coverage. Upon submission of the application, upload a copy of the insurance face sheet from the malpractice carrier or a copy of the federal tortletter or an attestation from the practitioner of federal tort coverage.

\* Do you have malpractice insurance or are you covered under a federal tort?  
 Yes  No

##### Add Malpractice

\* Malpractice type: -- Select One --  
 \* Effective Date:  \* Expiration Date:

Add

Add Malpractice  
 \* Malpractice type: FEDERAL TORT MALPRACTICE  
 \* Effective Date:  \* Expiration Date:

Add Malpractice  
 \* Malpractice type: INDIVIDUAL MALPRACTICE COVERAGE  
 \* Insurance Agency Name:  \* Amount:   
 \* Effective Date:  \* Expiration Date:

Add Malpractice  
 \* Malpractice type: MALPRACTICE COVERAGE UNDER A GROUP  
 \* Insurance Agency Name:  \* Amount:   
 \* Effective Date:  \* Expiration Date:

Step	Action
15	<p>In the <b>Work History</b> section of the <b>Provider Supplemental Information</b> page, enter your work history as a health professional:</p> <ul style="list-style-type: none"> <li>• Company Name – Employer name</li> <li>• Job Title – Position/job title</li> <li>• Start Date – Start date of the job title at this company</li> <li>• End Date – End date of the job. If you still hold this job title at this company, enter 12/31/9999.</li> </ul> <p>If the enrolling provider is currently a resident or intern, when entering work history he/she should enter the details of that residency/internship, such as:</p> <ul style="list-style-type: none"> <li>• Job Title: Resident</li> <li>• Company Name: Healthcare Facility XYZ</li> <li>• Start Date: Date residency/internship began</li> <li>• End Date: 12/31/9999 if still a resident/intern</li> </ul>
16	<p>In the <b>Education</b> section, enter your Education information:</p> <ul style="list-style-type: none"> <li>• School Name – School or institution name</li> <li>• Degree – Highest degree</li> <li>• Start Date – Date started at the school or institution</li> <li>• Graduation Date – Date graduated from the school with this degree</li> </ul>
17	<p>In the <b>Current Malpractice Insurance Coverage</b> section, enter/select the following:</p> <ul style="list-style-type: none"> <li>• Do you have malpractice insurance or are you covered under a federal tort? Select <b>Yes</b> if you have malpractice insurance or are covered under a federal tort.</li> <li>• Malpractice Type – Select the type of malpractice coverage.</li> <li>• Insurance Agency Name – Enter the name of the malpractice insurance agency.</li> <li>• Amount – Enter the amount of malpractice coverage.</li> <li>• Effective Date – Effective date of the coverage</li> <li>• Expiration Date – Expiration date of the coverage</li> </ul>
18	<p>Select <b>Next</b>.</p>

The **Exclusion Sanction Information** page displays.

**Re-Verification Application - Exclusion Sanction Information**

Indicates a required field

**WARNING!!! FAILURE TO DISCLOSE WILL RESULT IN AN APPLICATION DENIAL AND CAUSE ALL NON-DMH HEALTH PLANS TO TERMINATE. RE-ENROLLMENT WILL BE REQUIRED.**

**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 Date
01/05/2009
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

Step	Action
19	<p>Answer each question by selecting the <b>Yes</b> or <b>No</b> radio button.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• These questions pertain to all providers, owners, and managing employees listed in the provider record.</li> <li>• When <b>Yes</b> is selected for a question, the <b>Infraction/Conviction Dates</b> section displays. Select the appropriate date of the infraction or conviction. Select the <b>Add</b> button to add the information to the application.</li> <li>• At the end of this application, you must electronically upload 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 this application.</li> </ul>
20	Select <b>Next</b> .

The **Re-Verification Application – Federal Requirements** page displays for providers whose taxonomy classification is categorized as moderate or high risk. The PPM defines which providers/taxonomy codes are required to complete the federal requirements.

**Federal Requirements** Print | AA | Help

\* Indicates a required field Legend

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**FEDERAL SITE VISIT** ?

Based upon the health plans and taxonomy codes you have applied, your application requires you to complete a Federal Site Visit before your application will be approved.  
 If you completed a Federal Site Visit with another state Medicaid program, you must be able to provide proof of completion. If you are unable to provide proof, select NO.  
 If you completed a Federal Site Visit with Medicare, it must have been completed within 5 years of the submission date of this application. If the site visit was greater than 5 years, select NO.

\* Have you completed the Federal site visit for this site to NC Medicaid, another state or Medicare?

MEDICARE 21

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**FEDERAL FEE** ?

Section 6401(a) of the ACA requires the State Medicaid Agency to impose the fee. Based upon the health plans and taxonomy codes you have applied for, or your Bump Up Status, your application requires you to pay the Federal Fee.  
 If you paid the Federal Fee to another state Medicaid program, you must be able to provide proof of payment. If you are unable to provide proof, select NO.

\* Have you paid the Federal Fee for this site to NC Medicaid, another state or Medicare within the past five years?

OTHER STATE 22

\* Other State: FLORIDA

Please be sure to complete all required fields with valid data. 23

« Previous

Next »

Step	Action
21	<p>Answer the question <b>‘Have you completed the Federal site visit for this site to another state or Medicare?’</b></p> <ul style="list-style-type: none"> <li>• Answer <b>No</b> – If you have not had a site visit or are unable to provide proof of completion.</li> <li>• Answer <b>Medicare</b> – If you have had a site visit for Medicare certification purposes.</li> <li>• Answer <b>Other State</b> – If you have met this requirement for another state. If <b>Other State</b> is selected, you will need to select the state from the drop-down menu.</li> </ul>
22	<p>Answer the question <b>‘Have you paid the Federal Fee for this site to another state or Medicare?’</b></p> <ul style="list-style-type: none"> <li>• Answer <b>No</b> – If you have not paid the fee or are unable to provide proof of payment.</li> <li>• Answer <b>Medicare</b> – If you have paid the fee for Medicare certification purposes.</li> <li>• Answer <b>Other State</b> – If you have met this requirement for another state. If <b>Other State</b> is selected, you will need to select the state from the drop-down menu.</li> </ul> <p>Note: The Federal Requirements page displays the Federal Fee amount charged to a provider enrolling in NCTracks and is per application, the system will charge the Federal Fee only a single time for a provider, no matter how many of the provider’s service locations require the fee.</p>
23	Select <b>Next</b> .



The **Final Steps** page displays.

**Final Steps** Print | AA | Help

\* indicates a required field Legend

**24** 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.

**25** 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](#)

**26** 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.

**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

**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.

**27** [Upload Documents](#)

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

PDF documents on this page require the free [Adobe Reader](#) to view and print.

Step	Action
24	Print/save the Online Application and/or Cover Sheet. This will be the only opportunity to save, download, or print the PDFs.
25	In the <b>Application Fee Required</b> section, select the <b>Pay Now</b> button. The PayPoint landing page displays, allowing payment of the NC Application Fee.
26	When Fingerprinting is required, the system advises that the OA will be contacted with more information on completing the process.
27	In the <b>Electronic Attachments</b> section, select the <b>Upload Documents</b> button to navigate to the <b>Upload Documents</b> page to upload supporting documents. Documents required include the following: <ul style="list-style-type: none"> <li>• Supporting documents if the provider answered <b>Yes</b> to any of the questions on the <b>Exclusion Sanction Information</b> page.</li> <li>• Supporting documents if the provider completed the Federal Site Visit or paid the Federal Fee to another state.</li> <li>• Notification and Electronic Fingerprint Submission Release of Information Form if the application required fingerprinting and either the Individual provider or one of the owners has completed the fingerprinting process with NCTracks within the past 6 months.</li> </ul>

Step	Action
28	Select the <b>Provider Enrollment Status and Management Home</b> link to return to the <b>Status and Management</b> page.

The **Status and Management** page displays with the current status of the re-verification application.

**Provider Portal** | Home | Status and Management

**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: [NCTracksprovider@nctracks.com](mailto:NCTracksprovider@nctracks.com)

**Quick Links**  
[Online Application](#)  
[Advanced Medical Home Tier Attestation](#)  
[Provider Enrollment Home](#)  
[PE Supporting Information](#)  
[PE Terms and Conditions](#)  
[Reassign Existing Draft Applications](#)

**Status and Management**  
 \* indicates a required field

Welcome to Provider Enrollment Status and Management  
 Please choose from the options below to manage your enrollment status.

**SUBMITTED APPLICATIONS**

Below is the status of applications you have submitted.  
 If status is Payment Pending, we have received initial confirmation from Paypoint that your payment was confirmed; it may take up to 48 hours to verify the payment. If status is Pay Now, your NC Application Fee payment was not made or failed; click Pay Now to make payment.  
 If status of the application is in Payment Pending, Returned, or In Review, you can upload supporting documentation by clicking the Upload Documents hyperlink.

RECORD RESULTS						
NPI/Atypical ID	Name	DBA Name	Application Type	Submit Date	Status	
*****	*****	*****	RE-VERIFICATION	07/17/2018	Payment Pending	<a href="#">Pay Now</a> , <a href="#">Upload Documents</a> - Payment Pending
*****	*****	*****	MANAGE CHANGE REQUEST	10/09/2017	Manage Change Request Complete	

Statuses applicable to re-verification applications:

- **Abandoned:** Supporting documents were not electronically uploaded by the due date in the Application Incomplete letter, or the NC Application Fee was not paid within 30 days of the submission of the application.
- **In Review:** Application is being reviewed by CSRA or State.
- **Returned:** Application was returned to provider needing additional documentation from the provider. When the **Returned** link is selected, the provider will be redirected to the Application Incomplete letter.
- **Denied:** Your participation in the program has been denied.
- **Approved:** Your participation in the program has been approved.
- **Withdrawn:** CSRA or provider has withdrawn the application.
- **Pymt Pend:** (Payment Pending): Records indicate that you have made a payment at PayPoint. It may take up to 48 hours to verify a payment.
- **Pay Now:** You can select the **Pay Now** link to make your payment on the PayPoint website. It may take up to 48 hours to verify a payment.
- **Withdraw:** You can select the **Withdraw** link to withdraw your application.
- **Upload Documents:** You can select the **Upload Documents** link to electronically attach documents to your application.

## Appendix A. Sections of the Status and Management Page

### SUBMITTED APPLICATIONS SECTION

The **Submitted Applications** section displays the status of all submitted applications. Here, the provider is able to see the status specific to their submitted application. Some examples are Withdrawn, In Review, Abandoned, and Approved.

The screenshot shows the 'Submitted Applications' section of the NCMMIS system. At the top, there is a navigation bar with tabs for Eligibility, Prior Approval, Claims, Referral, Code Search, Enrollment, Administration, Trading Partner, Payment, Consent Forms, and Training. The 'Enrollment' tab is selected. Below the navigation bar, the page title is 'Status and Management' with a 'Legend' dropdown. A welcome message reads: 'Welcome to Provider Enrollment Status and Management. Please choose from the options below to manage your enrollment status.' The main content area is titled 'SUBMITTED APPLICATIONS' and contains a text box explaining the status of applications and a table of 'RECORD RESULTS'.

NPI/Atypical ID	Name	DBA Name	Application Type	Submit Date	Status
	MY BUSINESS III		Enrollment	06/14/2017	Pay Now , Upload Documents - Payment Pending
			Enrollment	06/13/2017	Pay Now , Upload Documents - Payment Pending
			Enrollment	06/13/2017	Pay Now , Upload Documents - Payment Pending
			Manage Change Request	06/12/2017	Upload Documents - In Review
			Enrollment	05/15/2017	Approved

### SAVED APPLICATIONS SECTION

The **Saved Applications** section displays those applications that have been initiated but have not yet been submitted. When you are ready to continue working with the application, you must select the NPI and select **Resume**. You may also delete the application by selecting **Delete Draft**.

The screenshot shows the 'Saved Applications' section of the NCMMIS system. It features a warning message: 'Please remember that your application must be 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.' Below this is a table of 'RECORD RESULTS' with columns for Select, NPI/Atypical ID, Name, DBA Name, ZIP Code, Application Type, Application Create Date, and Last Saved. At the bottom right, there are 'Resume' and 'Delete Draft' buttons.

Select	NPI/Atypical ID	Name	DBA Name	ZIP Code	Application Type	Application Create Date	Last Saved
<input type="radio"/>				27502-1216	Manage Change Request	07/21/2015	07/21/2015
<input type="radio"/>				27502-1216	Manage Change Request	07/01/2015	10/01/2015
<input type="radio"/>				48433-9451	Manage Change Request	07/27/2015	07/27/2015
<input type="radio"/>				27502-1216	Manage Change Request	07/21/2015	07/21/2015
<input type="radio"/>				27295-6848	Manage Change Request	10/12/2015	10/12/2015
<input type="radio"/>				27607-3073	Manage Change Request	07/23/2015	07/27/2015