



JOB AID

Submit a Prior Approval Request for Hearing Aids

Overview

This job aid provides the steps for submitting a Prior Approval (PA) request for hearing aids.

For further information on Hearing Aid Services and coverage, refer to Clinical Policy No. 7 – NC Division of Medical Assistance Hearing Aid Services.

Submit a Prior Approval Request

Once logged into the NCTracks Provider Portal, the user accesses the Prior Approval Request page through the Prior Approval tab.

Note: The Prior Approval menu may be different from the one displayed on this document based on your access rights.

CINTRACKS?									
Provider Portal Eligibit	ity Prior Approval	Claims	Referral	Code Search	Enrollment	Administration	Payment	Consent Forms	Training
+ Home	PA Entry								
Message Center for	PA Inquiry								Subscr
	Refraction Confi	rmation							
	Dental Benefit L	imitiation	-					More Annou	ncements
A COMPANY	Prescribing Prov Reviews	vider	0:00 A	M Attent	ion: All Pro	viders			
	Stay on top of NCTracks - sign up for the newsletter								
1201	The best way to newsletter. If y "Sign Up for NC receive not only	o stay on t you are no Tracks Co y the regu	op of updat it already ro ommunicati lar newslett	es to NCTracks eceiving the new ons" on the <u>Prov</u> er, but importar	is to subscrib vsletter, you c <u>vider Commur</u> nt time-sensiti	e to the NCTracks an subscribe by c <u>lications webpage</u> ve messages sent	Communica licking on th . Signing up t via email.	ations and Updates e link under the he o will ensure that y	eading You
	WELCON	AE.	OFFICE A	DMINISTRATORS	ENROL	LMENT			
AXA	Provid Traini	ler ng	l Admir	Jser histration	Statu Manag	s and ement			

Step	Action
1	Hover over the Prior Approval tab and click on PA Entry.

The Prior Approval Request page displays.

Step	Action
2	Complete the required fields in the Prior Approval Request Type section of the page:
	Select DMA as the payer.
	Select the appropriate Health Plan for the request
	 NCXIX = Medicaid
	 NCXXI = Health Choice
	Select HEARING AID as the PA Type.
3	Once the required fields are completed; click Submit .



TPACKS						4	, i	🚔 Welcome,	(Log.ou
									NGTracks Hel
rovider Portal	Eligibility	Prior Approval	Claims Referral	Code Search	Enrolment	Administration	Payment	Trading Partner	Consent Forms
Home + Prior Approval Request									
Prior Approval Requ	est								🖨 🗛 Help
Indicates a required field								1	Legend *
BASE INFORMATION			4						
* Account Information:	NCMMIS	1							
· Group:	NCMMIS				NPI /	Atypical ID:	111490493	27 •	
		12223						S1152	

Step	Action
4	Complete the required fields in the Base Information section of the page:
	Select the appropriate Account Information.
	Select the appropriate Group .
	Select the appropriate NPI/Atypical ID.
	Select the appropriate Locator Code.
	Select the appropriate Taxonomy Code.

Payer: DMA		PA Type: HEARING AI	
RECIPIENT -			
Recipient Information			
5 * Recipient ID:			
Last Name:		First Name:	
Address1:			
Address2:			
City:	State:	ZIP Code:	
Conder		Date of Birth-	

Step	Action
5	Under the Header Information tab, enter the Recipient ID in the Recipient Information section of the page.
6	Click Confirm . The recipient information will appear at the bottom of the section.

BILLING PROVIDER	ame as the requesting provider					•	?
7 * NPI;	1114904927 Select Favorite	01	r	Atypical Id:		8	Validate
9 * Address:	701 DOCTORS DR			10 * Taxonomy Code:	193400000X	- Single Specialty •	
Last Name:	KINSTON MEDICAL SPECIALISTS PA	ι		-	First Name:		
Address1:	701 DOCTORS DR						
Address2:	STEN						
City:	KINSTON	State:	NC		ZIP Code:	285011584	
Phone:	2525592200	Fax:					

Step	Action
7	Enter the NPI or Atypical ID field in the Billing Provider section of the page.
	 If applicable, click the checkbox for Billing Provider is the same as the requesting provider.
8	Click Validate.
9	Select the Address.
10	Select the Taxonomy Code.

lease en	ter up to 12 applicable diagnosi	is codes below		
DIAG	NOSIS INFORMATION			
	* Diagnosis Code	Diegnosis Type	Date of Onset (mm/dd/yyyy)	Primary
3		Choose 🔹	mm/dd/yyyyy 🗷	
			11	Add Cle
			-	

Step	Action
11	Complete the required fields in the Fitting Audiologist/Hearing Aid Dealer and Fitter:
	Enter the First Name.
	Enter the Last Name.
	Enter the Phone number.
	Note: The required fields in the Diagnosis Information section of the page are actually not required for a hearing aid prior approval request.



Step	Action						
12	Click Next.						
	You will be directed to the Detail Information tab.						
	Note: You may click one of the following options:						
	Save Draft to save changes to complete later.						
	Clear Page to clear the data entered.						
	Cancel Request to close the request without submitting.						





Detail Information Tab

	Payer: DMA		PA Type:	HEARING AI
nter all applicable dev	ice, accessory and dispensing code	s in the Proc Code field.		
BASIC LINE ITEM INFO	DRMATION			
Line #	* Service Type	* Proc Code	* Code Type	* Requested Begin Date
New	FM SYS NEW	v5130	HCPCS CODE	07/06/2015 🗵
Health Care Services Delive	ry Information			
Please provide the follo	wing additional information.			
Ser	viceUnits:		Unit Type:	Choose
м	odifier(s): 1: 2: 3: 4:		Place of Service:	Choose
F	requency:		Frequency Period:	Choose
	Duration:		Duration Type:	Choose -
	Detail Information Attachments			
	Payer: DMA		PA Type:	HEARING AI
	Payer: DMA		РА Туре:	HEARING AI
Enter all appli	Payer: DMA cable device, accesso	bry and dispensing	PA Type: codes in the Proc Code f	HEARING AI
Enter all appli	Payer: DMA cable device, accesso	ory and dispensing	PA Type: codes in the Proc Code f	HEARING AI
Enter all applic - BASIC LINE ITEN Line #	Detail Information Attachments Payer: DMA cable device, accesso t INFORMATION * Service Type	ory and dispensing (PA Type: codes in the Proc Code f	HEARING AI ield. * Requested Begin Date
Enter all applic - Basic Line Tree Line #	Detail Information Attachments Payer: DMA cable device, accessor throwmanne # service Type FM SYSTEM	ery and dispensing * Proc Code v5130	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE •	HEARING AI
Enter all applic	Detail Information Attachments Payer: DMA cable device, accessor t INFORMATION # Service Type FM SYSTEM Delivery information Delivery information	ery and dispensing of * Proc Code v5130	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE •	HEARING AI
Enter all applic BASIC LINE ITEM Line # New Health Care Services	Detail Information Attachments Payer: DMA cable device, accessor cable device, accessor cable fm System Privation callerer	ery and dispensing of * Proc Code v5130	PA Type: codes in the Proc Code f 13 * code Type ADA CODE •	HEARING AI
Enter all applie BASIC LINE ITEN Line # New Health Care Services Please provide th	Detail Information Attachments Payer: DMA Cable device, accessor INFORMATION # Service Type FM SYSTEM Delivery, Information e following additional information	ory and dispensing of * Proc Code v5130	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE •	HEARING AI ield. * Requested Begin Date 07/06/2015
Enter all applie BASIC LINE TIEN Line # New Health Care Services Please provide th Serv	Detail Information Attachments Payer: DMA Cable device, accessor Important State Import	ory and dispensing of * Proc Code v5130	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE • Unit Type: [HEARING AI
Enter all applie BASIC LINE ITEN Line # New Health Care Services Please provide th Serv Mo	Detail Information Attachments Payer: DMA Cable device, accessor Important in the service Type FM SYSTEM Delivery Information e following additional information iceUnits: differ(s): 1: 2: 3:	ory and dispensing of * Proc Code v5130	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE • Unit Type: [Place of Service: [HEARING AI
Enter all applie BASIC LINE ITEN Line # Convert Health Care Services Please provide th Serv Mo Fr	Detail Information Attachments Payer: DMA Cable device, accessor Cable device, accessor Cable device type FM SYSTEM Pelivery Information e following additional information iccUnits: differ(s): 1: 2: 3: equency:	ory and dispensing a state of the second state	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE • Unit Type: Place of Service: Frequency Period:	HEARING AI
Enter all applie BASIC LINE ITEN Line # New Health Care Services Please provide th Serv Mo Fr	Detail Information Attachments Payer: DMA Cable device, accessor Important on Important on Pelivery Information e following additional information iceUnits: differ(s): 1: 2: 3: equency:	ory and dispensing of * Proc Code v5130	PA Type: codes in the Proc Code f 13 * Code Type ADA CODE • Unit Type: [Place of Service: [Frequency Period: [HEARING AI ield. * Requested Begin Date 07/06/2015 2

Step	Actio	n		
13	From section	the Detail Informatio on: Select the Service Typ	n tab; complete the Basic Line Item Information	
		Short Description	Long Description	
		NEW HA B	NEW HEARING AID BOTH	
		NEW R HA	NEW RIGHT HEARING AID	
		NEW L HA	NEW LEFT HEARING AID	
		EAR MOLD	EAR MOLD	
		ACCESS	ACCESSORIES	
		INIT CARE	INITIAL CARE KIT	
		FM SYS NEW	FM SYSTEM NEW	
		FM SYS RPR	FM SYSTEM REPAIR	
		REPL FM S	REPLACEMENT FM SYSTEM/PART	
		REPAIR B	HEARING AID REPAIR BOTH	
		REPAIR R	HEARING AID REPAIR RIGHT	
		REPAIR L	HEARING AID REPAIR LEFT	

North Carolina Medicaid Management Information System (MMIS)



Step	Actio	on	
		DISP FEE	APPLICABLE DISPENSING FEE
		RPLC B WAR	REPLACEMENT HEARING AID BOTH / WARRANTY
		RPLC R WAR	REPLACEMENT RIGHT HEARING AID / WARRANTY
		RPLC L WAR	REPLACEMENT LEFT HEARING AID / WARRANTY
		RPLC B NWR	<u>REPLACEMENT HEARING AID BOTH / NON-WARRANTY</u>
		RPLC R NWR	REPLACEMENT RIGHT HEARING AID / NON-WARRANTY
		RPLC L NWR	REPLACEMENT LEFT HEARING AID / NON-WARRANTY
	• (Select the Service Typ)C.
		Short Description	Long Description
		NEW HA B	NEW HEARING AID BOTH
		NEW R HA	NEW RIGHT HEARING AID
		NEW L HA	NEW LEFT HEARING AID
		REPL HA	REPLACEMENT HEARING AID
		REPL R HA	REPLACEMENT RIGHT HEARING AID
		REPL L HA	REPLACEMENT LEFT HEARING AID
		REPL WARR	HEARING AID REPLACEMENT/ WARRANTY
		REPL N WAR	HEARING AID REPLACEMENT/NON-WARRANTY
		EAR MOLD	EAR MOLD
		ACCESS	ACCESSORIES
		INIT CARE	INITIAL CARE KIT
		FM SYS NEW	FM SYSTEM NEW
		FM SYS RPR	FM SYSTEM REPAIR
		REPL FM S	REPLACEMENT FM SYSTEM/PART
		CHILDREN	CHILDREN
		ADULTS	ADULTS
		REPAIR B	HEARING AID REPAIR BOTH
		REPAIR R	HEARING AID REPAIR RIGHT
		REPAIR L	HEARING AID REPAIR LEFT
		DISP FEE	APPLICABLE DISPENSING FEE
		RPLC B WAR	REPLACEMENT HEARING AID BOTH / WARRANTY
		RPLC R WAR	REPLACEMENT RIGHT HEARING AID / WARRANTY
		RPLC L WAR	REPLACEMENT LEFT HEARING AID / WARRANTY
		RPLC B NWR	REPLACEMENT HEARING AID BOTH / NON- WARRANTY
		RPLC R NWR	REPLACEMENT RIGHT HEARING AID / NON- WARRANTY
		RPLC L NWR	REPLACEMENT LEFT HEARING AID / NON- WARRANTY



Step Action

- Enter the **Procedure Code**.
- Select the Code Type.
- Select the Requested Begin Date.

Note: The **Health Care Services Delivery Information** section is optional. It is recommended to enter at least the requested number of units. However, a Prior Approval would be able to process with no need to complete these fields. If the user opts to complete these fields, they must **NOT** enter modifiers.

1							Validat
NPI:	1114904927	0	r	Atypical Id:			100000000
	Select Favorite		511				
Address:	701 DOCTORS DR			Taxonomy Code:	193400000X	- Single Specialty •	
Last Name:	KINSTON MEDICAL SPE	CIALISTS PA			First Name:		
Address1:	701 DOCTORS DR						
Address2:	STEN						
City:	KINSTON	State:	NC		ZIP Code:	28501-1584	
Phone:	2525592200	Fax:					

Step	Action
14	In the Rendering Provider section:
	 If applicable, click the checkbox for Rendering provider is the same as the billing provider.
	 Or manually enter the NPI or Atypical ID for the rendering provider. If entered manually, click Validate then select the Address and Taxonomy Code from their drop-down menus.
15	Click Add.





Hearing Aid Service Section

Please select the requested service	
💿 New Hearing Aid 💿 Hearing Aid Replacement 💿	Hearing Aid Repair 💿 Other
Ear Mold Information	
Are you requesting an ear mold?	
🕙 Yes 💩 No	
Accessory Information	
Are you requesting any accessories?	
🔿 Yes 💌 No	
FM System Information	
Are you requesting a FM system?	
🗇 Yes 🜻 No	
Other Device Information	
Are you requesting any device other than those indicat	ed above?
🖱 Yes 🔮 No	
Notes to Dries Assessed Baujawara	
notes to Prior Approval reviewer:	
	+
	an and a second se

Step	Action
16	In the Hearing Aid Service section, select the requested service as:
	New Hearing Aid (continue to Step <u>1</u> 6.1)
	Hearing Aid Replacement (continue to Step 16.2)
	Hearing Aid Repair (continue to Step 16.3)
	Other (continue to Step 16.4)
	Once the requested service is selected, the screen expands to enter information on the requested hearing aid device or repair.





Hearing Aid Service Section – New Hearing Aid

If the requested service is for a new hearing aid, the screen will expand with required fields specific to this request.

	Please select the requested service					
	New Hearing Aid Hearing Aid Replacements	ement 💿 Hearing Aid Rep	air 💿 Other			
	We Hearing Ald Information					
L6.1	Right Ear · · · · · · · · · · · · · · · · · · ·		* Name/Model #1		* Invoice Cost:	0.00
	* Type: Choose					
	* Style: Choose	-				
5.1.1 🕂	Has the patient previously been provided I Yes No	with this service?				
	- PREVIOUS SERVICES RENDERED					
				Funding 5	ource	
	* Date Residered					

Step	Action
16.1	 Complete the required fields in the New Hearing Aid Information section: Select the check box for Right Ear or Left Ear. You may also select both check boxes for Right Ear and Left Ear if applicable.
	• Complete the required fields for each device. Note, as a provider, you will need to know and identify where to obtain the following information:
	 Manufacturer Name/Model # Invoice Cost
	 Type – select one of the following: Analog
	 Analog Digital Other
	 Style – select one of the following:
	BTE CIC
	• ITC
	 ITE Other
16.1.1	The system will prompt you to answer the following question: "Has the patient previously been provided with this service?"
	Select Yes or No to answer the question.
	If yes, the screen will expand with the Previous Services Rendered section.
	Enter the Date Rendered.
	Enter the Funding Source.
16.1.2	Click Add.





Hearing Aid Service Section – Hearing Aid Replacement

If the requested service is for a hearing aid replacement, the screen will expand with required fields specific to this request.

Hearing Air	d Replacement Information		and He repression of one	
Right Right Ear	it Ear 📃 Left Ear			
	· Manufacturer:		* Name/Model #:	Invoice Cost: 0.00
	* Туре:	Choose 💌		
	· Style:	Choose .		
	e patient previously been p	provided with this service	a7	
+ Has the				
Has the	es 🖯 No			

Step	Action
16.2	Complete the required fields in the Hearing Aid Information Replacement section:
	• Select the check box for Right Ear or Left Ear . You may also select both check boxes for Right Ear and Left Ear if applicable.
	 Complete the required fields for each device. Note, as a provider, you will need to know and identify where to obtain the following information:
	– Manufacturer
	– Name/Model #
	 Invoice Cost
	 Type – select one of the following:
	 Analog Digital
	 Other
	 Style – select one of the following:
	• BTE
	CIC TC
	• ITE
	Other
16.2.1	The system will prompt you to answer the following question; "Has the patient previously been provided with this service?"
	Select Yes or No to answer the question.
	If yes, the screen will expand with the Previous Services Rendered section.
	Enter the Date Rendered.
	Enter the Funding Source.
16.2.2	Click Add.





Hearing Aid Service Section – Hearing Aid Repair

If the requested service is for hearing aid repair, the screen will expand with required fields specific to this request.

* Please select the	e requested service	Meaning Aid Benair Cother		
Haaring Aid Benair I	nformation	reading not repair to wante		
	Invoice Cost: 0.00			
	Description:		(a 	
Document	tation of Medical Necessity:			
			250 charactery remaining	
Has the patient Nes 0 1	previously been provided with this ser No	rvice?		
Has the patient	previously been provided with this ser No INVICES REMOVING Data Rendered	vice?	 runding Source	

Step	Action
16.3	Complete the required fields in the Hearing Aid Repair Information section. Note, as a provider, you will need to know and identify where to obtain the following information:
	Invoice Cost
	Description
	Documentation of Medical Necessity
16.3.1	Select Yes or No to answer the question; "Has the patient previously been provided with this service?"
	If yes, complete the required fields from the expanded screen as described in the previous step table of this document.
16.3.2	Click Add.





Hearing Aid Service Section – Other

If the requested service is for something other than a new hearing aid, hearing aid replacement or repair, the screen will not expand with any other fields.

HEARING AID SERVICE	?
Verage select the requested service New Hearing Aid @ Hearing Aid Replacement @ Hearing Aid Repair @ Other Ext Hed Information	?
Are you requesting an ear mold? Yes No	
Accessory Information Are you requesting any accessories?	?
FM System Information Are you requesting a FM system? 16.4	?
Other Device Information Are you requesting any device other than those indicated above? Yes No	?
Notes to Prior Approval Reviewer:	
(I Previous	♪ Submit

<u>Step</u>	Action
<u>16.4</u>	Complete the complete the device information questions as explained in the following section of this document.

Hearing AHearing Aid Service Section - Other

16. 4 – If the requested service is for something other than a new hearing aid, hearing aid replacement or repair, select **Other** as the Hearing Aid Service. From here, complete the device information questions.

Hearing Aid Service Section – Device Information Questions

Several **Yes** or **No** questions regarding the hearing device are presented under the Hearing Aid Service section. These questions are not required to be answered and will default to a **No** answer. If you answer **Yes** to any of the questions, the screen will expand for you to provide more information regarding your answer.

Are you requesting an ear mold?

Ear Mold Information Are you requesting an ear mold?			?
Ear Mold Details	17	Invoice Cost: 1000	

Step	Action		
17	If you answer Yes ; you must complete the expanded fields:		
	• Ear: Select whether the mold is for the left, right, or both ears.		
	Invoice Cost: Enter the total amount of cost.		





Are you requesting any accessories?

Accessory Information Are you requesting any accessories? Yes © No			£
Accessory Details	18		
Initial care kit should not be billed separately when t	billing a new hearing aid.		
* Accessory Type: REPL TUBE	* Quantity: 2	* Total Invoice Cost: 500	

Step	Action		
18	If you answer Yes ; you must complete the expanded fields:		
	Accessory Type: Select the accessory from the drop-down list.		
	• Quantity: Enter the total number requested for that particular accessory.		
	Total Invoice Cost: Enter the total amount of cost.		

Are you requesting an FM system?

	[FM System Information Are you requesting a FM system? Yes © No	[?]	
		FM System Details * Type: FM SYSTE	M • Manufacturer: Clear Sound Inc. Name/Model #: Clarify 123abc	
19		Transmitter	Receiver 🔲 Audio Shoe/Boot	
			# Invoice Cost: 1250 Inder Warranty	
*Has the patient previously been provided with this service? • Yes • No				
PREVIOUS SERVICES RENDERED				
	н	* Date Rendered	* Funding Source	
	L	06/05/2013 🛃	My Insurance	
	ľ		21 Add Clear	

Step	Action
19	Note: You may refer to Clinical Policy #7 – Section 3.2.1.3: FM Systems, to learn more.
	If you answer Yes ; you must complete the expanded fields:
	Type: Select the accessory from the drop-down list.
	Manufacturer: Enter the name of the manufacturer.
	Invoice Cost: Enter the total amount of cost.
	Complete any other non-required field that you deem appropriate.
20	Answer the follow-up question; "Has the patient previously been provided with this service?"
	If yes, the screen will expand with the Previous Services Rendered section.
	Enter the Date Rendered.
	Enter the Funding Source.





Are you requesting any device other than those indicated above?

ľ	Original Serial #			
	* Invoice Cost:	1250		
	Description:	FM System Name/Model: Clarify 111abc	*	
			*	
	Documentation of	Recipient obtained this service due to	*	
	Medical Necessity:		*	
			209 characters remaining	
_				
*	Has the patient previously been	provided with this service?		1
*	Has the patient previously been Yes O No	provided with this service?		
*	₩Has the patient previously been	provided with this service?		
*	W Has the patient previously been ● Yes ○ No = PREVIOUS SERVICES R	provided with this service?		
*	# Has the patient previously been	provided with this service? ENDERED dered	Funding Source	

Step	Action		
22	If you answer Yes; you must complete the expanded fields:		
	Invoice Cost: Enter the total amount of cost.		
	• Description : Place detailed information regarding other devices requested.		
	 Documentation of Medical Necessity: Enter detailed information regarding the medical necessity for this device(s) 		
23	Answer the follow-up question; "Has the patient previously been provided with this service?"		
	If yes, the screen will expand with the Previous Services Rendered section.		
	Enter the Date Rendered.		
	Enter the Funding Source.		
24	Click Add.		





Notes to Prior Approval Reviewer

Notes to Prior Approval Reviewer:	* 500 characters renaining	
α Previous		Next. D Submit

Step	Action
25	Enter any pertinent information that will allow the PA reviewer to make a timely and correct decision on the approval for the requested hearing aid service.

« Previous	
Step	Action
26	Click Next.
	You will be directed to the Attachments tab.
	Note: You may click:
	Previous to go back to the previous tab.
	Save Draft to save changes to complete later.

- Clear Page to clear the data entered.
- **Cancel Request** to close the request without submitting.





Attachments Tab

You will be given the opportunity to attach any documents that support your request for a hearing device accessory or repair.

Note: You may refer to Clinical Policy #7 – Section 3.2.1.3: Hearing Aid Services, to complete this section.

Payer:	DMA				PA Type: HEA	RING AI
PPROVAL REQUEST ATTACHMENT Does this Approval request Yes No	s t have any attachments?					1
Diesse enter up to 9 file att.	achments helow out to eve	east 25Mb total				
Please enter up to 9 file att	achments below not to exe	ceed 25Mb total.	ssion Code	# Attachmer	at Control #	* Attachment Supplement
Please enter up to 9 file att ATTACHMENTS # ATT HEALTHCLIN	achments below not to exe achment Type	eed 25Mb total. * fransmit UPLOAD	ssion Code	* Attachmer 123456	it Control #	* Attackment Supplement
Please enter up to 9 file att ATTACHMENTS # ATTA HEALTHCLIN	achments below not to exe achment Type	eed 25Mb total. Transmit UPLOAD	ssion Code •	* Attachmer 123456	it Control #	* Attachment Supplement Up 29 the Add Clear

Step	Action
27	Note: You may refer to Clinical Policy #7 – Attachment B: 3.2.1.3: Instructions for Submitting Attachments for Electronic Prior Approval Requests and Claims, to learn more.
	No answer. Select Yes , if you will include supporting documents attached to this request.
28	Complete the required fields from the expanded Attachments section:
	Attachment Type: Lists types of supporting documentation.
	• Transmission Code: How the user will submit the documentation.
	 Fax – The application provides a fax number to fax the attachment.
	 Mail – The application provides a mailing address to mail the attachment.
	 Upload –The application provides an Upload File button to allow the user to locate and add the attachment to the PA request.
	Note: Uploaded attachments are limited to nine total items, with all items not to exceed 25 MB, total. If the user attempts to load a file larger that 25MB, the spinning wheel icon may display indefinitely.
	 Attachment Control #: The number the provider attaches to the documentation.
	• Attachment Supplement: File name of the attachment being added. Select the file to attach through the Upload File button.
	Note: If selecting MAIL or FAX as the transmission option, the cover sheet



Step	Action					
	generated by the system MUST be included with the documentation to be sent. If it is not, CSC does will not be able to scan and attached the documentation to the appropriate PA.					
29	Click Add.					
30	Click Submit.					
	Note:					
	• Once submitted, the request will be validated by the system and a record will be submitted to NCTracks if no data errors or other issues are presented.					
	If an error occurs, a message will appear indicating the type of error and the field(s) with the error will be highlighted. Once corrections have been completed, you may re-submit the request.					
	• A confirmation page will display with the PA confirmation number and a link to a PDF for the information entered.					
	Other options aside from submitting the PA are:					
	 Previous to go back to the previous tab. 					
	 Save Draft to save changes to complete later. 					
	 Clear Page to clear the data entered. 					
	 Cancel Request to close the request without submitting. 					