ADDENDUM AND ATTESTATION OF CORRECTED IDENTIFYING INFORMATION
NC MEDICAID PROVIDER ENROLLMENT- REVERIFICATION APPLICATIONS ONLY

Provider Name: _____

NC Medicaid Provider NPI/Atypical ID: _____

Reverification Application Reference Number: _____

Purpose

This Addendum and Attestation is to be used only in connection with a pending Reverification Application submitted to NC Medicaid.
This form is used to correct the Full Name, Date of Birth (DOB), and/or Social Security Number (SSN) previously submitted on the Reverification Application when the information does not match information obtained during the required background verification process. In lieu of withdrawing the Reverification Application, this Addendum and Attestation may be submitted with supporting documentation to verify the correct information.
The following information is inaccurate and should replace the information previously submitted on the Reverification Application identified above.

Correction

Corrected Full Name of Individual/Date of Birth/Social Security Number (print):

_____
_

Supporting Documentation

Attach documentation required for the correction being requested. Refer to the table under the appropriate the **Type of Change - Required Documentation** announcement for acceptable forms of documentation. Failure to provide acceptable supporting documentation may result in delays in processing the Reverification Application

Attestation Statement

I, _____(printed name), acting in my capacity as the authorized Office Administrator for the provider/entity identified above, hereby attest that the data offered in this addendum and attestation and all supporting documentation are true, accurate, and complete to the best of my knowledge.

I understand that NC Medicaid may request additional documentation to verify the information provided. I further understand that failure to provide complete and accurate enrollment information may result in administrative action, including the denial of the application, termination from the NC Medicaid program, or other actions permitted by applicable federal and state laws and program requirements.

Office Administrator Signature:
_____**Date:**_____