



JOB AID How to Manage Your NCTracks Addresses

OVERVIEW

This job aid provides step-by-step instructions for how to manage your NCTracks addresses using the Manage Change Request process in the NCTracks system.

Logging into the Provider Portal

- 1. Navigate to <u>www.nctracks.nc.gov</u>
- 2. The following page will display. Select the "Providers" tab at the top of the page.







3. From the "Providers" page, **select** the "NCTracks Secure Portal" icon.



4. The following login screen will display. **Enter** the NCID and password and **select** the "Log in" button.

| ovider Portal Login | AA Help |
|--|--|
| The NCTracks Web Portal contains information that is private and confidential. | |
| Only users of legal age or with parental consent authorized by the North Carolina Medicaid Manager (NC MMIS) may utilize or access NCTracks Web Portal for approved purposes. Any unauthorized use disclosure of this system or any information contained therein is prohibited and may result in revoca legal action. If you are not an authorized individual, this private and confidential information is not i are not authorized to access this content, please click 'Cancel'. | nent Information Systems a, inappropriate use, or stion of access and/or intended for you. If you |
| NC MMIS retains the right to monitor, record, distribute, or review any user's electronic activity, file evidence of illegal or actionable activity may be disclosed to law enforcement officials. | es, data, or messages. Any |
| By continuing, you agree that you are authorized to access confidential eligibility, enrollment and o coverage information. Please read more in our <u>Legal</u> and <u>Privacy Policy</u> pages. | ther health insurance |
| YOUR ACCOUNT | |
| All users are required to have an <u>NCID</u> to log in to secure areas. | |
| Passwords are case-sensitive. Please ensure your Caps Lock key is off. | |
| User ID (NCID): Password: Forgot Password | |
| | an formeral |

Accessing the Manage Change Request Application

1. The following Providers page will display. Select the "Status and Management" button.







2. The "Status and Management" screen will display. The screen is divided into 7 sections.

| mormation | | |
|--|---|---|
| of Provider Enrollment, please A Cell Center. | * indicates a required field | Legend |
| 00-688-6696 | Welcome to Provider Enrollment Status and Management | |
| 55-710-1965 | Please choose from the options below to manage your enrollment status. | |
| Tracksprovider@nctracks.com | | |
| | SUBMITTED APPLICATIONS | |
| | | |
| inks | Below is the status of applications you have submitted. | |
| olication | If status is reyment renaing, we have received initial confirmation from Paypoint that your payment was confirmed; it may take up to 48 nours to payment if status is Pay New your NC application Fee payment was not made on failed; citic Pay New your NC application Fee payment | venity the |
| Medical Home Tier | If status of the application is in Payment Pending, Returned, or in Review, you can unload supportion documentation by clicking the Unload Docum | ents |
| <u>n</u> | hyperlink. | |
| er Enrollment Home | | |
| porting Information | + RECORD RESULTS | |
| ns and Conditions | | |
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For additional information on the Status Manage Change Request, see the Participant User Guide "Provider Web Portal Applications Participant User Guide." Navigate to the "Manage Change Request" section.

Entering a Manage Change Request

To begin a new "Manage Change Request", under the "Manage Change Request" Section, **select** the radio button next to the NPI to be changed. Next, **select** the "Update" button.







| MANAG If you Organ please The fo which | e CHANGE REI are a behaviou ization (LME/M e ensure your l bollowing provid- you would like CORD RESULTS | QUEST ral health provider contra ICO) and you update you LME/MCO has the same u er accounts associated v e to submit a Manage Cha s | acted with a Local Management Ir data in a NCTracks Manage Cl Ipdated data on file. vith your NCID are active. Pleas ange Request, then click ' Upda t | Entity/Manag hange Reques e select the a re'. | ged Care It application account with | , , |
|---|--|---|---|--|--|--------------------|
| Select | NPI/Atypical ID | Name | DBA Name | ZIP Code | Begin Date | Status |
| 0 | | BRUCE, ALPHA J | | 27260 | 03/24/1998 | Active |
| O | | COMMUNITY PHYSICIANS | | 27607-0028 | 02/06/2017 | Active |
| O | | COMMUNITY PHYSICIANS | THE LEARNING CENTER | 27607-3073 | 09/01/2014 | Active |
| O | | COMMUNITY PHYSICIANS | | 27607-3073 | 01/07/2015 | Active |
| 0 | | DEMO PROVIDER | JOY JOHNS | 27265-3277 | 07/22/2013 | Active |
| O | | GATE CITY TRANSPORTATION INC | GATE CITY TRANSPORTATION INC | 27406-1398 | 04/01/2008 | Active |
| ۲ | | Sherlock, Holmes | PAIN MANAGEMENT AND REHAB: PC | 27948-8516 | 09/04/2013 | Active |
| 0 | | COUNTY HEALTH DEPT | COUNTY HEALTH DEPT | 27610-1808 | 11/20/1973 | Active |
| | | | | | | Update † |

1. In order to update address information the provider will need to select "Complete multiple changes or review your complete provider record."

| | | NCTracks Help | | | | | |
|---|--|-----------------------|--|--|--|--|--|
| Provider Portal | Eligibility Prior Approval Claims Referral Code Search Enrollment Administration Payment Trading Partner Consent Forms | | | | | | |
| Home Provider Enrollment Online Provi | ider Enrollment Ap | | | | | | |
| Contact Information | Requested Manage Change Request Type | 📾 A A <u>Help</u> | | | | | |
| If you have any questions regarding completion of Provider Enrollment, please contact CSRA Call Center. | Indicates a required field | Legend 🔻 | | | | | |
| Phone: 800-688-6696 | MANAGE CHANGE REQUEST TYPE | ? | | | | | |
| Email: NCTracksorovidenBioctracks.com | Select the type of Manage Change Request you would like to complete. | | | | | | |
| | NPI/Atypical ID: 1003000399 | | | | | | |
| Quick Links | Name: COMMUNITY PHYSICIANS | | | | | | |
| Online Application | OUpdate Electronic Funds Transfer (EFT) Account Information | | | | | | |
| Advanced Medical Home Tier | O Add/Update Method of Claim and Electronic Transactions and/or Billing Agent Information1 | | | | | | |
| Provider Enrollment Home | Complete multiple changes or review your complete provider record | | | | | | |
| @ PE Supporting Information | 1Please have all information available, this application must be completed in one session. | | | | | | |
| PE Terms and Conditions | | + | | | | | |
| Applications | | | | | | | |
| | | Next 1) | | | | | |
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| | | | | | | | |

2. The "Organization Basic Information" screen will display. The left hand side menu will display a list of topics.



Do NOT **select** the menu options on the left hand side of the screen, as each page must be accessed/reviewed and marked with a check mark before the "Manage Change Request" can be submitted. Instead, to navigate to appropriate section, Select the "Next" button on the bottom right corner of the screen until you reach the "Addresses" screen.





CSRA

| Provider Portal | Eligibility Prior Approval Claim | is Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms | • | |
|---|----------------------------------|---------------------------|---------------|-------------|----------------|-------------|---|---------------|-----------|------|
| Home Provider Enrollment Online | e Provider Enrollment Ap | | | | | | | | | |
| Provider Enrollment | Organization Basic Ir | formati | on | | | | | | AA I 🖨 | Help |
| NOTE: Data is not saved unless the | * indicates a required field | | | | | | | | Legend | Ŧ |
| Contact CSRA Call center 🖀 | DENTIFYING INFORMATION | | | | | | | | | ? |
| Organization Basic Information | If you need to update the O | rganization N | lame, submit | documentat | ion that shows | proof of a | legal name cha | nge to CSRA v | ia fax at | |
| Terms and Conditions | 855-710-1965 or by email a | at NCTracks | provider@nctr | acks.com. | | | | | | |
| Health/Benefit Plan Selection | Organization Name: | | | | | | | | | |
| Ownership Information | EIN: | 22-22222 | 22 | | NPI/Atypical | Provider II |): | | | |
| Addresses | * Email: | TEST@FAK | EEMAIL. | | Month of Fisc | al Year End | d: January | - | | |
| Taxonomy Classification | | | | | | | | | | + |
| Add Services and Endorsements | | | | | | | | | | |
| Accreditation | DOING BUSINESS AS (DBA) | | | | | | | | | £ |
| CCNC/CA | Yes No | ide or compa | iny name? | | | | | | | |
| Hours of Operation | DBA Information | | | | | | | | | |
| Services | * DBA Name: | | | | | | | | | |
| Agents/Managing Employees | * Years Doing Business | 2 | | | | | | | | |
| Method of Claim/Electronic Submission | Under This Name: | | | | | | | | | |
| EFT Account Information | | | | | | | | | | + |
| Exclusion Sanction Information | a | | | | | | | _ | | ? |
| Review Application | * Business Type: | CORPORAT | TON | | - | Pleas | e be sure to comp fields with valid co | ontent. Nex | t 33 | |
| | | | | | | | | Save | Draft | + |
| | REGISTERING WITH NC SECRETARY | OF STATE register with | n NC Secretar | y of State? | | | | | | ? |
| | | | | | | | | | | |

3. On the "Terms and conditions" page, to attest and accept Medicaid Terms and Agreements, **select** the check box and **select** the "Next" button.

| have not herein knowingly or willfully falsified, | ment are true, accurate, complete, and current as of the date this attestation is signed. concealed or omitted any material fact that would constitute a false, fictitious or |
|---|--|
| raudulent statement or representation. | |
| | |

Updating the Primary Physical Address

Address Validation Enhancements: Before you begin, please read the following important address validation enhancement information.

During provider Initial Enrollment, Manage Change Request and Re-enrollment applications, a change has been made to the address validation for the following pages to allow the provider to attest that the address is valid and continue the application even if the address is not deemed valid by the address verification:

- Addresses Page: Primary address and Servicing addresses only
- Preventive Ancillary Services Page: Lab addresses
- EFT page: Bank address
- Ownership Info Page: Owner's address

Note: Pay-To and Correspondence addresses must be deliverable and are excluded from the override.

1. The following Addresses screen will display. **Enter** the new Office Phone (If different), Street Address, City, State and Zip Code. **Select** the "Verify Address" button.

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| ddresses | | | 🖴 AA |
|--|---|-----------------------------------|--|
| Indicates a required field | | | Legend |
| PRIMARY PHYSICAL LOCATION | | | |
| This is the primary physical locati | on where service will be rendered, or in the ca | ase of mobile services, where mar | nagement/supervision occurs. |
| * Office Phone #: Begin Date: | × ext. | Office Fax #: [0 | 000) 000-0000 nd Date It |
| Warning: The provider record the provider record. | must contain at least one active service locat | tion to remain active. Removing o | or end dating all service locations will termina |
| Address * Address Line 1: | | | |
| Address Line 2: | 1022-008 | | |
| | Contract of the second s | * State: | NORTH CAROLIN |
| * City: | | | |
| * City: * ZIP Code: | | County: 1 | Wake |

| To ensure the accuracy of the address, NCTracks verifies the entered information against the United States Postal Service (USPS) database. As long as the address matches the USPS database, the Addresses screen will refresh with the new address. This is shown in the image above. |
|---|
| Note: If the primary physical address is changed here it will be effective as of the date the request was submitted. |
| If the address does not match the USPS database, NCTracks will display the following error message. In order to proceed, the provider must update and re-verify the address OR select the checkbox below the address to attest that the address is valid. |

| | | Error Summary |
|---------------|---|---|
| | | |
| 12:1 | Please fix the following errors before you proceed. | Click each error message to navigate to the field requiring correction or data |
| | entry. | |
| | Primary Location: Address is not a valid USPS of address, please select the 'Valid Address' check | enverable address. Please review and correct the address. If this is your valid |
| | ····· | |
| | | |
| PRIMARY PHYS | ICAL LOCATION | |
| This is the r | primary physical location where service will be rendered, or i | in the case of mobile services, where management/supervision occurs, |
| | , | |
| | * Office Phone #: (000) 000-0000 ext. | Office Fax #: (000) 000-0000 |
| Address | | |
| | * Address Line 1: | End Date It |
| | Address Line 2: | |
| | * City: | * State: NORTH CAROLIN |
| | 710 Cada | Country |
| | | |

2. Next, **place** a check-mark next to each servicing county.





| Note to CCNC/CA provide CCNC/CA enrollees. | rs: In addition to your county, plea | ase select the contiguous coun | ties for which your practice will a | accept |
|---|--------------------------------------|--------------------------------|-------------------------------------|--------|
| CHENDERDON | E HERT OID | LITIONL | ETHIDE | 11 |
| IREDELL | JACKSON | I JOHNSTON | JONES | |
| LEE | LENOIR | LINCOLN | MACON | |
| MADISON | MARTIN | MCDOWELL | MECKLENBURG | |
| MITCHELL | MONTGOMERY | MOORE | I NASH | |
| INEW HANOVER | INORTHAMPTON | ONSLOW | C ORANGE | [|
| PAMLICO | PASQUOTANK | PENDER | PERQUIMANS | |
| PERSON | E PITT | POLK | RANDOLPH | |
| RICHMOND | ROBESON | ROCKINGHAM | ROWAN | |

3. Next, if your organization has separate "Pay-To" or "Correspondence" addresses, select the appropriate options and enter the appropriate addresses. You will also need to **select** the Verify Address buttons for each of these options (if applicable).

Updating the 1099 Reporting/Pay-to Address

This section allows the user to verify if a provider does or doesn't have a separate corresponding address.

Note: All enrolled NPIs that share the same EIN will be updated with the new address.

- 1. Enter the 1099 Reporting/Pay To Address, City, State, Zip Code and Verify the address.
- 2. Enter the 1099 Reporting/Pay To Contact Person contact information: Last Name, First Name, Office Phone #, Contact Email.

| provider records with the bmit one application per EI | same Employee Identification Number N. Upon application approval, all reco | r (EIN) must have the same : ords with the same EIN will be | 1099 Reporting Address e updated with the new | . You only need t address. |
|--|---|--|--|-------------------------------|
| / To Attention: | | | | |
| * Address Line 1: | | | | |
| Address Line 2: | ; | | | |
| * City: | RALEIGH | | | |
| * State: | NORTH CAROLIN | * ZIP Code: | 27607-3073 | |
| | | | | Verify Addre |
| Pay-To Contact Person | | | | |
| ontact person is: | | | | |
| * Last Name: | | * First Name: | | |
| Middle Name: | - | Suffix: | Select One 💌 | |
| Office Phone #: | ext. | Office Fax #: | (000) 000-0000 | |
| | | | | |





Updating the Correspondence Address

- This section allows the user to enter a separate correspondence address, if applicable. This address will be used by CSRA for termination letters, appeals and various other communication. You are required to keep your correspondence address current. You may be suspended or terminated if the correspondence address is not accurately maintained and updated in the NCTracks systemEnter the Correspondence Address, City, State, Zip Code and Verify the address.
- 2. Enter the Correspondence Contact Person contact information: Last Name, First Name, Office Phone #, Contact Email.

| this is the address there an poper and decounting consepon | dence is to be malled. |
|--|------------------------------|
| Send Correspondence To | |
| Attention: | |
| * Address Line 1: | |
| Address Line 2: | |
| * City: RALEIGH | |
| State: NORTH CAROLIN - | * ZIP Code: 27607-3073 |
| | Verify Addre |
| Correspondence Contact Person | |
| Contact person is: | |
| * Last Name: | * First Name: |
| Middle Name: | Suffix: Select One - |
| * Office Phone #: e:t. | Office Fax #: (000) 000-0000 |
| | |



3. Next, if your organization has additional Service Locations, select the appropriate options and enter the appropriate addresses. You will also need to select the Verify Address buttons for each of these options (if applicable).

Adding Additional Service Locations

This section allows the user to enter additional service location information, if applicable.

- 1. Enter the Service Location Office Phone, Address, City, State, Zip Code, Begin Date and **Verify** the address.
- 2. Select "Add".





| SERVICE LOCATIONS * Do you have additional service locations? • Yes • No Service Locations | ? |
|---|----------------|
| + SERVICE LOCATION 2 - | ? |
| Add Service Locations | |
| Please complete all the required fields and click the Add button. | |
| Service Location Name: Office Phone #: (000) 000-0000 ext. Office Fax #: (000) 000-0000 | |
| * Address Line 1: | |
| Address Line 2: * City: * State: * ZIP Code: 00000-0000 County * Begin Date: mm/dd/yyyy I | Verify Address |
| | Add Clear |

3. When you have finish updating or adding all address, **select** "Next" to continue the Manage Change Request.

Completing the Manage Change Request

1. Continue to **select** the "Next" button through the Manage Change Request application until you reach the Review Application page. For additional information on completing the Manage Change Request, see the Participant User Guide "*Provider Web Portal Applications Participant User Guide*."



The **Save Draft** button will only save your progress and will not submit the Change Request for processing.

| | | * |
|------------|---|--------------|
| « Previous | Please be sure to complete all required fields with valid content. | Next » |
| | Save Draft | Delete Draft |

 The Review Application screen will display. On the left hand margin, verify that all application pages have a green check mark next to each page. In addition, verify the contact email address listed on the page. This can be updated on the Basic Information page.

To review the application in Adobe PDF format, **select** the "Review Application" button. If you have successfully completed all required information for your provider enrollment application and are satisfied the information is complete and accurate, **select** the "Next" button to proceed to the "Attachments/Submit Electronic Application" page.





| eview Application | 🖨 A- A+ E |
|---|--|
| ELECTRONIC SIGNATURE - EMAIL CONFIRMATION | |
| Please confirm that the email address below is correct. If you do Electronic Signature PIN will be sent to this address upon subr access to this email address to retrieve/reset your PIN and comp If the email below is incorrect, you may now navigate back to th update it. (Remember to click 'Next' on the <u>Basic Information page</u> to store | on't already have one, an mitting the next page. You will need plete this Online Application. ne <u>Basic Information page</u> to re your change.) |
| Contact Email: abc@123.com | |
| REVIEW APPLICATION | |
| To review your application in Adobe PDF format, click 'Review Appli successfully completed all required information for your provider enror the information is complete and accurate, you may proceed to the A Application page by clicking ' Next '. | ication' below. If you have ollment application and are satisfied Attachments/Submit Electronic |
| | Review Application 🔎 |
| | |
| Previous | Next 1 |

3. The "Sign and Submit Electronic Application" page will display. **Enter** the NCID and password, as well as the "PIN" number and **select** the "Submit Now" button.

| Sign and Submit Electronic Application | |
|---|---|
| * Indicates a required field | Legend 👻 |
| If for any reason you navigate away from this page without clicking 'Submit Now', you will be required to re-enter the informa ELECTRONIC SIGNATURE CONTINUATION Attestation: I have read and agreed to the terms and conditions of participation. By submitting this form, I confirm the inform the documents submitted with the application/rerolment documents/administrative Participation Agreement are true, accura current as of the date this electronic document is submitted. I do hereby attest that any falsification, on ission, or concealm may subject me to administrative, civil, or criminal lability. # Login ID (NCID): # Password: | tion. ? mation contained in te, complete, and ent of material fact |
| Ecropt Login ID Fornot Password If this is your first Provider Enrollment submission, your Electronic Signature PIN has now been sent to retrieve it now to complete submission. If the email is incorrect, you may now mavigate back to the Basic Information pay (Remember to cick Next on the Basic Information pays to store your change.) If there is a PIN already associated with this NCID, please use it now. If you have forgotten your PIN, you may reset it b ID (NCID) and Password and cicking the Forgot PIN hit. The PIN will be sent to your email address. | c.com. Please ge to update it. ry entering you Login |
| Please contact the CSECCECCECCE at 800-688-6686 if you have any trouble with your Electronic Signature PIN Number. | |
| Trading Partner: Agreement Agreement and Attestations REQUIRED ATTACHMENTS 3001 Dr, RALEIGH, NC 27609-7362 | 2 |
| Your application indicates that you are enrolling as: RESPIRATORY, DEVELOPMENTIAL, REMABILITATIVE AND RESTORATIVE SERVICE PROVIDERS, Physical Therapist, None The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or • No Required Attachments for the Taxonomy | r by regular mail. |
| Concine Application Submission | ? |
| You may now submit your Online Application by clicking 'Submit Now' below. After submitting you will have the option to prin completed application for your records. | nt a copy of the |
| You will also receive instructions to finalize the application process on the next page. Note: If you click 'Submit Later' button, electronic signature information and the attached files will not be saved. | |
| Submit Later Submit Now | |
| & Previous | |
| | Delete Draft |





TIPS FOR NAVIGATING THE MANGE CHANGE REQUEST APPLICATION

All pages must be reviewed prior to continuing. If you receive the following error, **select** on the pages that do not have check marks next to the section and **select** "Next" through those sections.

| ĺ | Error Summary |
|---|---|
| ſ | Please fix the following errors before you proceed. Please complete all pages in this application before proceeding. |
| l | |

The image below shows the unchecked pages that need to be reviewed.

| Provider Enrollment | Review Application | | |
|--|--|-------------------------------------|--|
| NOTE: Data is not saved unless the 'Next' button is activated. | * indicates a required field | Legend | |
| Contact CSRA Call center 🔤 | Error Summary | | |
| Organization Basic Information | Please fix the following errors before you proceed. | | |
| Terms and Conditions | Please complete all pages in this application before proceeding. | | |
| Health/Benefit Plan Selection | | | |
| Ownership Information | CEMAIL CONFIRMATION | | |
| Addresses | | | |
| Taxonomy Classification | The below email address is the email for the Office Administrator for this provider. During the approval process, communication will be sent to this email address. If the email below is incorrect, you may now navigate back to the <u>Basic Information page</u> to update it. (Remember to click Next on the <u>Basic Information page</u> to store your change.) | | |
| Add Services and Endorsements | | | |
| Accreditation | Contact Email: | | |
| CCNC/CA | | | |
| Hours of Operation | REVIEW APPLICATION | | |
| Services | To review your application in Adobe PDF format, click 'Review Application' below. If you h completed all required information for your provider enrollment application and are satisfied | ave successfully the information is | |
| Agents/Managing Employees | complete and accurate, you may proceed to the Attachments/Submit Electronic Application page by clicking | | |
| Method of Claim/Electronic Submission | | | |
| EFT Account Information | Rev | iew Application 🍋 | |
| Exclusion Sanction Information | | + | |
| Review Application | // Previnus | plete all Next 1 | |

Common Errors When Updating Addresses

1. The address is recognized as having a secondary unit, such as an apartment number, suite, department, or room number at a single address, it may result in the following error message.

| Error Summary | |
|---|--|
| Please fix the following errors before you proceed. Click each error message to navigate to the field requiring correction or data entry. | |
| <u>ServiceLocation: Missing Apt/Suite Number</u> | |

To resolve the error, enter the applicable Apartment, Suite or Floor Number in either the Address Line 1 or Address Line 2. The entry is not case sensitive. For example, "Suite" may be entered as "STE" or "Ste".





You may also verify your address at the USPS website: https://tools.usps.com/go/ZipLookupAction!input.action

IMPORTANT: The format of the Apartment, Suite or Floor Number must match the format that is used by the USPS. Reference the list of approved abbreviations.

* Does not require secondary range of numbers to follow the abbreviation

| Secondary Unit Designator | Approved Abbreviation |
|---------------------------|-----------------------|
| APARTMENT | APT |
| BASEMENT | BSMT * |
| BUILDING | BLDG |
| DEPARTMENT | DEPT |
| FLOOR | FL |
| FRONT | FRNT * |
| HANGAR | HNGR |
| LOBBY | LBBY * |
| LOT | LOT |
| LOWER | LOWR * |
| OFFICE | OFC * |
| PENTHOUSE | PH * |
| PIER | PIER |
| REAR | REAR * |
| ROOM | RM |
| SIDE | SIDE * |
| SLIP | SLIP |
| SPACE | SPC |
| STOP | STOP |
| SUITE | STE |
| TRAILER | TRLR |
| UNIT | UNIT |
| UPPER | UPPR * |

2. If the street name is not a recognized by USPS, it may result in the following error message. Double-check the formatting and spelling of the street name.

| | | Error Summary | | | |
|--------------------------------------|--|--|--------------------|---------------------------------------|---|
| | Please fix the correction or • <u>Primary I</u> | following errors before you proceed. Click e data entry. Location: Address Not Found | ach error messa | ge to navigate to the field requiring | |
| PRIMARY PH This is the occurs. | HYSICAL LOCATION - e primary physical I | ocation where service will be rendered, or in th | e case of mobile s | ervices, where management/supervision | ? |
| | * Office Phone #: Begin Date: | (313) 444-2222 ext 05/01/2012 | Office Fax #: | (000) 000-0000 End Date It | |
| Address - | * Address Line 1: | 2610 Easy Street |] | | |







FINAL STEPS

You will be able to save/print the online application and the review agreement from the "Final Steps" screen. This page also contains the final steps you must take in order to complete the application process ("Pay Now" and/or "Upload Documents").

If you are required to complete the fingerprinting process as identified in the Provider Permission Matrix, you will be notified on this page.

| Provider Portal | Eligibility Prior Approval Claims Referral Code Search Eurodiment Administration Trading Partner Payment Consent Forms |
|---|---|
| • Home • Provider Enrollment • Online P | rovider Enrollment Ap |
| Provider Enrollment | Final Steps 🕮 🗛 Help |
| Contact EVC Center | * indicates a required field |
| | Online Submission Complete |
| | Thank you for submitting the colline portion of your application. Please save/print the following documents for your records • <u>Online Application</u> • <u>Cover Sheet</u> Now that you have submitted your online application, you will not be able to retrieve the application or reprint application documents. |
| | APPLICATION FEE REQUEED ? Thank you for applying to Modicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC Application Fee and a Federal Fee is required in the amount of \$569.00. Please click the 'Pay Non' button to pay the \$669.00. You will be directed to Paypoint to make the payment. Pay Now |
| | BEQUIRED ATTACHAENTS ST Struckletun Rd, APCX, NC 27502-1216 Your application indicates that you are enrolling as: ACENCIES, Program of All Inclusive Care for the Elderly (PACE) Provider Organization, None GROUP, Multi-Speciality, N |
| | The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail. Copy of PACE program agreement from CHS |
| | EJECTRONIC ATTACHNENTS |
| | 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 |
| | REGUISTS SUPPLIAENTAL DOCUMENTS [7] In order to complete year application, you must print, complete, and sign the regulard <u>NC DHHS Health Check Agreement between Primary Care Provider</u> |
| | Return to <u>Frovider Enrollment Status</u> and Management Home |
| | PDF documents on this page require the free Adobe Reader to view and print. |