



a General Dynamics Information Technology, Inc. company

NCMMIS Provider Web Portal Applications (Providers) Participant User Guide

PREPARED FOR:

North Carolina Department of
Health and Human Services

DHHS MES VMU

TRACKING NUMBER:

PUG_PRV111
Version V7.9
FINAL

SUBMITTED BY:

CSRA
a General Dynamics
Information Technology,
Inc. company



NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

September 26, 2024

**ATTENTION - THIS TRAINING IS INTENDED FOR COVERED ENTITIES
AND BUSINESS ASSOCIATES WHO ARE CONSIDERED TO BE
STAKEHOLDERS OF THE NCTRACKS APPLICATION.**

Document Revision History

Version	Date	Description of Changes
V7.9	September 26, 2024	Updated for CSR 2670 (cosmetic changes)
V7.8	September 04, 2024	Final version
D7.8.1	August 22, 2024	Updated for CSR 2758
V7.7	June 10, 2024	Final version
D7.7.1	June 07, 2024	Updated for Service Ticket 28011
V7.6	May 09, 2024	Updated for CSR 2742 (cosmetic chgs)
V7.5	December 07, 2023	Final version
D7.5.1	December 05, 2023	Updated for CSR 2708
V7.4	June 29, 2023	Final version
D7.4.1	June 27, 2023	Updated for Service Ticket 27101
V7.3	June 15, 2023	Final version
D7.3.1	June 13, 2023	Updated for CSR 2671
V7.2	May 02, 2023	Final version
D7.2.1	April 27, 2023	Updated for CSR 2590
V7.1	March 17, 2023	Final version.
D7.1.1	March 15, 2023	Incorporated State review recommendations.
V7.0	March 08, 2023	Final version
D7.0.1	March 03, 2023	Update for CSRs 2620, 2624, 2661
V6.9	October 24, 2022	Final version
D6.9.1	October 14, 2022	Update for CSR 2481
V6.8	October 04, 2022	Final version
D6.8.1	September 30, 2022	Update
V6.7	April 28, 2022	Final version
D6.7.1	April 26, 2022	Update for CSR 2510
V6.6	January 10, 2022	Final version
D6.6.1	January 06, 2022	Update for CSR 2435.
V6.5	May 12, 2021	Final version
D6.5.2	May 10, 2021	Addressed State review comments
D6.5.1	May 03, 2021	Update for CSR 2401
V6.4	January 07, 2021	Final version
D6.4.1	December 29, 2020	Updated Federal fee, per FMR 11456.
V6.3	October 27, 2020	Final version
D6.3.1	October 22, 2020	Update for Silk Ticket 24109
V6.2	August 12, 2020	Final version
D6.2.1	August 07, 2020	Update for CSR 2303.
V6.1	July 29, 2020	Final version
D6.1.1	July 24, 2020	Addressed State review comments.
V6.0	July 10, 2020	Final version.
D6.0.1	July 07, 2020	Update for CSR 2303
V5.7	March 30, 2020	Final version.
D5.7.1	March 24, 2020	Update for Service Ticket 22964.
V5.6	January 14, 2020	Cosmetic change: Update to Federal fee in Addendum C.
V5.5	May 09, 2019	Final
D5.5.1	May 06, 2019	Update for CSRs 2095.2 and 2095.5
V5.4	January 16, 2019	Final

Version	Date	Description of Changes
D5.4.1	January 10, 2019	Update for CSR 2095.1
V5.3	November 15, 2018	Final
D5.3.1	November 09, 2018	Update for CSR 2070
V5.2	July 25, 2018	Final
D5.2.1	July 20, 2018	Update for CSR 2075
V5.1	May 25, 2018	Final
D5.1.2	May 23, 2018	Responded to State review comments
D5.1.1	May 11, 2018	Update for FMR 6915.
V5.0	March 27, 2018	Final
D5.0.2	March 22, 2018	Responded to State review comments
D5.0.1	March 08, 2018	Updated for CSR 1984
V4.2	February 19, 2018	Final
D4.2.2	February 14, 2018	Responded to State review comments
D4.2.1	February 05, 2018	Submission for review/acceptance
D4.1.3	January 29, 2018	Responded to State review comments
V4.1	January 29, 2018	Final
D4.1.2	January 18, 2018	Responded to State review comments
D4.1.1	January 04, 2018	Updated for CSR 2004
V4.0	December 15, 2017	Final
D4.0.2	December 13, 2017	Responded to State review comments
D4.0.1	November 15, 2017	Updated for CSR 1994
V3.3	May 10, 2017	Final
D3.3.2	May 09, 2017	Responded to State review comments.
D3.3.1	March 15, 2017	Updated for CSR 1985
V3.2	June 21, 2016	Final
D3.2.1	June 15, 2016	Updated for CSR 1872.
V3.1	October 16, 2015	Final
D3.1.1	October 09, 2015	Revised per State recommendation.
V3.0	October 08, 2015	Final
D3.0.2	October 05, 2015	Revised per State comments.
D3.0.1	September 24, 2015	Updated for CSR 1797.
V2.0	June 24, 2015	Final
D2.0.2	June 19, 2015	Second update submission.
D2.01	June 03, 2015	Updated for CSR 810 and CSR 1635.
V1.1	February 12, 2015	Final version
D1.1.3	February 11, 2015	Third submission
D1.1.2	February 04, 2015	Second submission
D1.1.1	January 27, 2015	Revised for CSR 862.
V1.0	April 03, 2013	Final version
D1.0.3	April 02, 2013	Third submission
D1.0.2	March 28, 2013	Second submission
D1.0.1	March 19, 2013	Initial submission

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1.0 Welcome

1.1 COURSE OVERVIEW

Welcome to this course on Provider Web Portal Applications – Providers. This course will guide you through the process of submitting all types of provider applications found on the NCTracks Provider Portal. This course will also detail what to expect once your applications have been submitted.

1.2 COURSE BENEFITS

This course will guide you through an overview of the Initial Enrollment (including Out-of-State [OOS], OOS Lite, and Ordering, Prescribing, and Referring [OPR] Lite), Re-enrollment, Re-verification, Maintain Eligibility, Fingerprinting Required, and Manage Change Request (MCR) application processes. It will also detail the **Status and Management** page, which is used to submit and track your applications.

1.3 COURSE OBJECTIVES

At the end of this training, you will be able to:

- Understand the Provider Enrollment Application processes
- Navigate to the NCTracks Provider Portal and complete the following Provider Enrollment Application processes: Initial Enrollment, MCR, Re-enrollment, Re-verification, Fingerprinting Required, and Maintain Eligibility
- Track and submit applications using the **Status and Management** page

1.4 PREREQUISITES

- HIPAA Security & Privacy Training
- Computer-Based Training (CBT) NCTracks Overview Provider Portal – Providers

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2.0 Provider Web Portal Applications

2.1 INTRODUCTION

You must be enrolled with the NC Department of Health and Human Services (DHHS) to render services. There are several different types of applications that you might use, depending on the circumstances of your application. They are:

- [Initial Enrollment](#) – You will complete an Initial Enrollment application if you want to newly enroll with NC DHHS (including OOS and OPR providers).
- [Manage Change Request](#) – You can update your information (addresses, phone numbers, e-mail addresses, Electronic Funds Transfer [EFT] information, etc.) by submitting an MCR application after the Provider Enrollment application is approved.
- [Re-enrollment](#) – If you have been terminated in all health plans and want to re-enroll, you will submit a Re-enrollment application.
- [Re-verification](#) – As a provider, you are required to complete a Re-verification application every 5 years.
- [Fingerprinting Required](#) – Required when providers have enrolled, re-enrolled, added locations with certain taxonomies in an MCR, or completed Re-verification since August 2015.
- [Maintain Eligibility](#) – If you have not had any claim activity within the last 12 months, you are required to complete a Maintain Eligibility application if you intend to stay active.

2.2 OBJECTIVES

This Participant User Guide will provide step-by-step documentation of the processes to complete and submit provider enrollment applications.

A majority of the demonstration sections will have graphic illustrations followed by numbered **steps**. The numbers on the images will correspond with the numbers in the **steps**.

Note: For more information on the Enrollment Specialist (ES) user role, refer to Participant User Guide PRV 562 *Enrollment Specialist User*.

Note: Abbreviated MCR applications allow providers to update EFT information, add/update affiliations, and add/update their method of claim and electronic transactions and/or billing agent. For more information on the Abbreviated MCR options, refer to Participant User Guide PRV 563 *Abbreviated Managed Change Request*.

2.3 HELP SYSTEM

The major forms of help in the NCTracks system are as follows (refer to Addendum A):

- Navigational breadcrumbs
- System-Level Help – Indicated by the “NCTracks Help” link on each page
- Page-Level Help – Indicated by the “Help” link above the Legend
- Legend
- Data/Section Group Help – Indicated by a question mark (?)
- Hover-over or Tooltip Help on form elements

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3.0 Initial Enrollment

3.1 NAVIGATING TO PROVIDER APPLICATIONS – INITIAL ENROLLMENT

You will navigate to Provider Applications via the NCTracks Provider Portal.

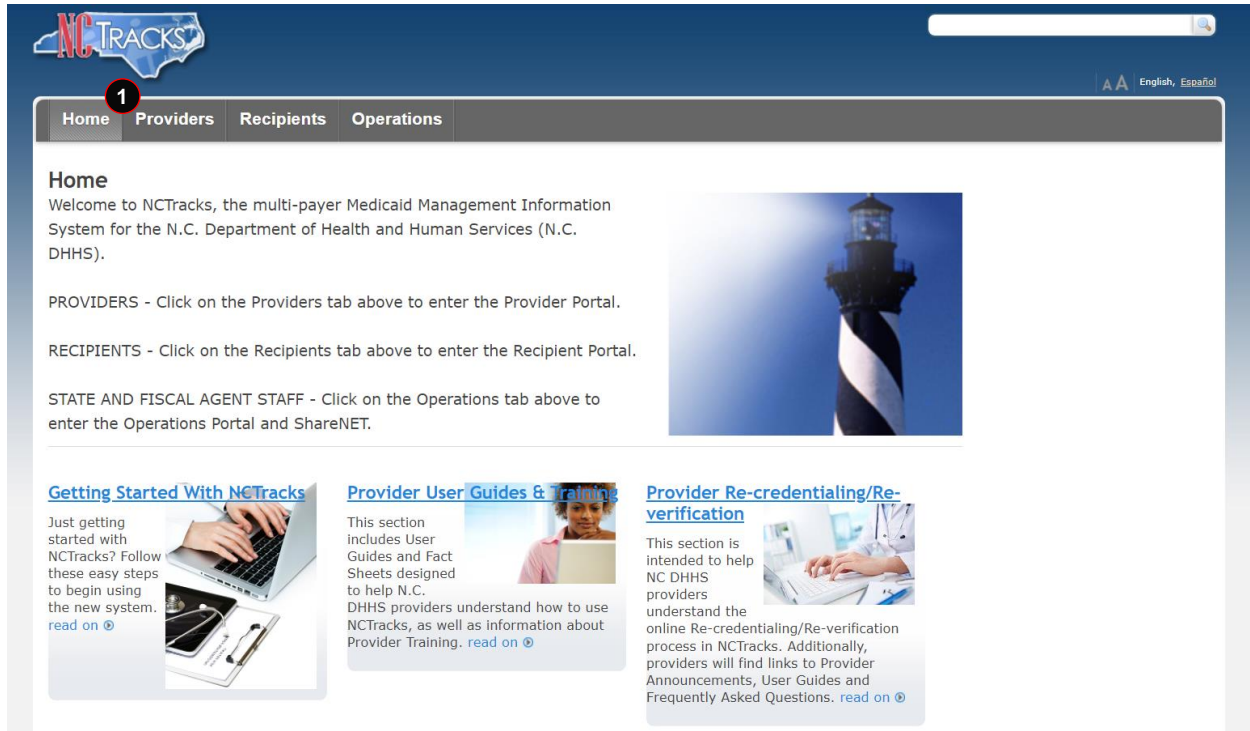


Exhibit 1. NCTracks Home Page

Step	Action
1	Navigate to the NCTracks website (www.nctracks.nc.gov) using a supported browser. Select the Providers tab. The public Providers page displays.

[Home](#)
[Providers](#)
[Recipients](#)
[Operations](#)

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

Getting Started With NCTracks

Provider Communication

Frequently Asked Questions

Currently Enrolled Provider (CEP) Registration

Claims

Prior Approval

1 Provider Enrollment

2 Getting Started With Enrollment

Supporting Information

Terms and Conditions

Enrolled Practitioner Search

ICD-10

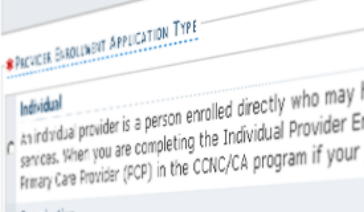
Provider Re-credentialing/Re-verification

Provider Policies, Manuals, Guidelines and Forms

Provider User Guides and Training

Provider Enrollment

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



The enrollment process includes credentialing, endorsement, and licensure verification. The CSRA Enrollment Team completes this verification to ensure that all providers meet the professional requirements and are in good standing. Once participation as a DHHS provider has been approved, providers are notified by email and may begin submitting claims to NC DHHS for services rendered.

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

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

[Fingerprinting Information Page](#)

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

Contact

CSRA Call Center

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

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

E-Mail
NCTracksprovider@nctracks.com

Quick Links

[Re-verification Refresher \(PDF, 1767 KB\)](#)

[Provider Enrollment Frequently Asked Questions \(FAQs\)](#)

Exhibit 2. Public Providers Page

Step	Action
1	Select Provider Enrollment ; menu options display.
2	Select the Getting Started With Enrollment menu option. The Getting Started page displays.

[Home](#)
[Providers](#)
[Recipients](#)
[Operations](#)

[Home](#) > [Providers](#) > [Provider Enrollment](#) > Getting Started With Enrollment

Getting Started With NCTracks

Provider Communication

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Provider Enrollment

Getting Started With Enrollment

Supporting Information

Terms and Conditions

Enrolled Practitioner Search

ICD-10

Provider Re-credentialing/Re-verification

Provider Policies, Manuals, Guidelines and Forms

Provider User Guides and Training

Dental Services

Getting Started With Enrollment

The Provider Enrollment Online Application is a user-friendly web application that gathers all the information needed to enroll you or your organization as a licensed Medicaid provider in North Carolina. The following information will help you get started with your application.

To assist you with completing an application, you will need the required information readily available. See the [Provider Permission Matrix](#). Providers [within 40 miles](#) of the border of North Carolina are eligible to provide in-state Medicaid services for the State of North Carolina.

Once you have completed minimal required information for your application, you will be given the opportunity to save it as draft for later completion.

When you are completing an Individual or Organization Provider Enrollment application, you will be given the option to also enroll as a Primary Care Provider (PCP) in the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) program if your provider type qualifies you to participate. See [CCNC/CA Eligible Provider Types](#) for more details.

You may begin your Provider Enrollment Online Application [here](#).

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

Contact

CSRA Call Center

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

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

E-Mail
NCTracksprovider@nctracks.com

Quick Links

[CCNC/CA Eligibility](#)

[North Carolina Border ZIP Codes](#)

[Provider Enrollment Frequently Asked Questions \(FAQs\)](#)

[Provider Permission Matrix \(XLSX, 811 KB\)](#)

[Provider Permission Matrix Instructions \(PDF, 507 KB\)](#)

Exhibit 3. Getting Started Page

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

[Home](#) > [NCTracks Provider Portal Login](#)

[A](#) [English](#) [Español](#)

Provider Portal Login

Important Announcement

NCTracks Multi-Factor Authentication (MFA) Updates Coming Soon for Individual & Business Users

In accordance with the [North Carolina Identity Management \(NCID\) Citizen Identity Project](#), NCTracks is changing the User Login process and implementing Multi-Factor Authentication (MFA) updates. Please complete the following steps to update your NCID profile by **Sept. 6, 2024**, in advance of the MFA updates:

These instructions are for Individual and Business users only, not Local and State Government users.

1. Login to the MyNCID portal at <https://myncidpp.nc.gov/> with your NCID Username and Password.
2. You will see the Profile Information page upon successful login.
3. Click on the **MFA** tab on your profile page.
4. Click on the **ADD ENROLLMENT** button on the bottom right.
5. A pop-up window will appear prompting you to choose an MFA method. Please note that office phone extensions are not supported.
6. Follow the onscreen prompts to add your chosen MFA method.

For detailed instructions, including images of each step, refer to the [NCID User Guide for MFA](#).

Important Note: Providers who do not currently use MFA will not be impacted at this time. MFA updates will be implemented through a phased approach. Until that time, your current login method will continue to work. However, you are being asked to update your profile to ensure a seamless transition to the new MFA method. You will receive further communication when your MFA is to be updated.

If you are an Individual or Business User who currently uses MFA, these updates will impact you on Sept. 15, 2024. Once these updates are implemented you are no longer required to access and maintain MFA using <https://mfaportal.nc.gov/nctracksmfa>. All profiles, including MFA, will be managed through <https://myncid.nc.gov/> after implementation.

If you encounter issues during login or authentication, please contact the Department of Information Technology (DIT) helpdesk at **519-754-6000** or **800-722-3946**.

For more information and training videos, visit the [NCID Citizen Identity Project | NCIDIT training page](#).

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 Management Information Systems (NC MMIS) may utilize or access NCTracks Web Portal for approved purposes. Any unauthorized use, inappropriate use, or disclosure of this system or any information contained therein is prohibited and may result in revocation of access and/or legal action. If you are not an authorized individual, this private and confidential information is not intended for you. If you are not authorized to access this content, please click 'Cancel'.

NC MMIS retains the right to monitor, record, distribute, or review any user's electronic activity, files, data, or messages. Any evidence of illegal or actionable activity may be disclosed to law enforcement officials.

By continuing, you agree that you are authorized to access confidential eligibility, enrollment and other health insurance coverage information. Please read more in our [Legal](#) and [Privacy Policy](#) pages.

All users are required to have an NCID to log in to their secure area. An NCID does not grant access to all secure areas. Access to a specified secure area is allowed per the user access rights granted by NCDHHS (State users) or the provider's Office Administrator. Recipient NCIDs does not require additional rights to access Recipient portal.

To create/update NCID record, use the appropriate link as per your NCID type.

- External Users (Provider or Recipient) click [here](#)
- State and Local Government employees (State or Fiscal Agent) click [here](#)

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Powered By

Exhibit 4. NCTracks Login Page

Step	Action
1	<p>Select the NCTracks Secure Portal button.</p> <p>Note: It is assumed that your Office Administrator (OA) will be the person who is completing the application. The OA will log in with their NCID and password. If logging in as an ES, refer to the Participant User Guide PRV 562 <i>Enrollment Specialist User</i>.</p>

Exhibit 4.1 NCTracks Login Page

Step	Action
2	<p>User ID: Enter your NCID username.</p> <p>Note: In order to log in to the secure Provider Portal of NCTracks, all users must have an NCID. If you do not have an NCID, you can select the Register Now link displayed on the login page, which will navigate you to the NCID home page.</p>

Exhibit 4.2 NCTracks Login Page

Step	Action
3	Enter the Password associated with the NCID.
4	Select the Sign On button.

If a user is supposed to go through Multi-Factor Authentication (MFA), the State NCID system will prompt with preselected MFA preference. On successful verification of MFA, the user is navigated back to the desired secure Portal page.

Supplemental Points: Passwords are case-sensitive. After three unsuccessful attempts, the user will be locked out; however, NCTracks will provide a contact number to call for access assistance. Multi-Factor Authentication is required. Once the user has entered the User ID and password, the second level authentication is sent via the user's preferred method. For more information on the MFA registration process, please refer to the **NCID Citizen Identity Project** at the following site:

<https://it.nc.gov/support/ncid/ncid-citizen-identity-project#Tab-Training-4404>

3.2 ONLINE PROVIDER ENROLLMENT APPLICATION PAGE

On the **Online Provider Enrollment Application** page, you will enter your ZIP code in order for NCTracks to determine if you are an In-State, Border, or OOS provider. You will also select your **Provider Enrollment Application Type**.

PROVIDER LOCATION

Please enter the 9-digit ZIP Code (ZIP +4) of your primary practice location for determination of In-State, Border, or Out-of-State enrollment.

1 * ZIP Code: 00000-0000

2 * PROVIDER ENROLLMENT APPLICATION TYPE

INDIVIDUAL PROVIDERS

INDIVIDUAL FULL ENROLLMENT

☐ An individual provider is a person enrolled directly who may have an affiliation with an organization or may bill independently for services. When you are completing the Individual Provider Enrollment application, you will be given the opportunity to also enroll as a Primary Care Provider (PCP) in the CCNC/CA program if your provider type qualifies you to be a PCP.

ORDERING, PRESCRIBING, REFERRING PROVIDERS ENROLLED WITH THE LITE APPLICATION

☐ With the implementation of Section 6405 of the Affordable Care Act, CMS requires certain physicians and non-physician practitioners to enroll in the Medicaid program for the sole purpose of ordering, referring, or prescribing items or services for Medicaid or Health Choice beneficiaries (42 CFR 455.410).

OUT-OF-STATE PROVIDER ENROLLED WITH THE LITE APPLICATION

☐ As a time-limited OOS provider (lite), your enrollment will automatically be end-dated one year after your Effective Date Requested entered on the application. You will be required to re-enroll if you wish to continue participation after the one year. This option only applies to providers whose primary address is outside the 40 mile border area.

MEDICARE ONLY LITE PROVIDER

☐ As a time-limited Medicare-only provider (lite), you are enrolling for submission of cost-sharing claims, adjudication of cost-sharing claims, and issuance of a Medicaid RA. This process will facilitate your ability to receive a Medicaid RA and claim Medicare bad debt. Your enrollment will automatically be end-dated one year after your Effective Date Requested entered on the application. You will be required to re-enroll if you wish to continue participation after the one year.

DISASTER RELIEF PROVIDER ENROLLMENT

☐ Disaster Relief lite enrollment is intended for qualified providers who have provided services for recipients during a disaster response period, not for providers who see recipients on an ongoing basis.

I confirm that I have or will provide services to a North Carolina beneficiary

ATYPICAL INDIVIDUAL

☐ Are you an atypical individual? As defined by CMS: Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal regulations at 45 CFR section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI.

ORGANIZATION PROVIDERS

ORGANIZATION FULL ENROLLMENT

☐ An Organization is an entity, facility, or institution that may be an affiliation of individual providers. When you are completing an Organization Provider Enrollment application, you will be given the opportunity to also enroll as a PCP in the CCNC/CA program if your provider type qualifies you to be a PCP.

OUT-OF-STATE PROVIDER ENROLLED WITH THE LITE APPLICATION

☐ As a time-limited OOS provider (lite), your enrollment will automatically be end-dated one year after your Effective Date Requested entered on the application. You will be required to re-enroll if you wish to continue participation after the one year. This option only applies to providers whose primary address is outside the 40 mile border area.

MEDICARE ONLY LITE PROVIDER

☐ As a time-limited Medicare-only provider (lite), you are enrolling for submission of cost-sharing claims, adjudication of cost-sharing claims, and issuance of a Medicaid RA. This process will facilitate your ability to receive a Medicaid RA and claim Medicare bad debt. Your enrollment will automatically be end-dated one year after your Effective Date Requested entered on the application. You will be required to re-enroll if you wish to continue participation after the one year.

DISASTER RELIEF PROVIDER ENROLLMENT

☐ Disaster Relief lite enrollment is intended for qualified providers who have provided services for recipients during a disaster response period, not for providers who see recipients on an ongoing basis.

I confirm that I have or will provide services to a North Carolina beneficiary

ATYPICAL ORGANIZATION

☐ Are you an atypical organization? As defined by CMS: Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal regulations at 45 CFR section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI.

BILLING AGENT PROVIDERS

BILLING AGENT

☐ Billing Agents and Clearinghouses are third party entities—businesses—that submit information directly to CSRA as the NC DHHS Fiscal Agent on behalf of an enrolled provider.

Exhibit 5. Online Provider Enrollment Application Page

Step	Action
1	ZIP Code: Enter your ZIP Code .
2	Provider Enrollment Application Type: Select Individual Full Enrollment, Organization Full Enrollment, Atypical Individual, Atypical Organization, or Billing Agent .

3.3 ORGANIZATION BASIC INFORMATION PAGE

The **Organization Basic Information** page captures basic information for Organization providers. If you are enrolling as an Individual provider, skip to [Section 3.4. Individual Basic Information Page](#).

Note: If additional information is required on enrolling as an OOS Lite or full provider, please refer to Participant User Guide PRV 595 *Out-of-State Provider Enrollment*.

The screenshot displays the 'Organization Basic Information' page in the NCMMIS Provider Portal. The page is divided into several sections, each with a numbered callout:

- 1**: Identifying Information section, including fields for Organization Name, EIN, NPI, Email, and Month of Fiscal Year End.
- 2**: Does Business As (DBA) section, with a checkbox for 'Do you operate under a trade or company name?' and radio buttons for 'Yes' or 'No'.
- 3**: Business Type dropdown menu, currently set to 'CORPORATION'.
- 4**: A checkbox labeled 'The Business Type entered on this application matches what was reported to the provider's state business registration entity.'
- 5**: Office Administrator (Authorized Individual) section, including fields for User ID (NCID), Last Name, First Name, Middle Name, Contact Email, Office Phone #, and Office Fax #.
- 6**: Effective Date Requested section, with a date field and a checkbox for 'I attest that the Requested Effective Date is correct and understand that it cannot be changed once the application is submitted.'
- 7**: A checkbox for 'I attest that I have entered the full legal name of the individual, and the individual does not have a middle name.'
- 8**: A checkbox for 'Is this contact person an Owner or Managing Employee?' with radio buttons for 'Owner' or 'Managing Employee'.

The page also includes a 'Next' button at the bottom right and a footer with system information.

Exhibit 6. Organization Basic Information Page #1

Step	Action
1	Identifying Information: Enter Organization Name , EIN , NPI , Email , and Month of Fiscal Year End .

Step	Action
2	<p>Doing Business As (DBA): Answer Yes or No to the question: ‘Do you operate under a trade or company name?’.</p> <ul style="list-style-type: none"> If you answer Yes, the field will expand, prompting you to enter the DBA Name and Years Doing Business Under This Name. Note: The DBA Name must be registered in the county where the service is being provided. If you answer No, you may continue to the next required field on the page.
Note	<p>The Organization Name and DBA Name fields only allow the following characters:</p> <ul style="list-style-type: none"> Alpha (A – Z) Numeric (0 – 9) Hyphen (-) Ampersand (&)
3	<p>Ownership Information: Select the Business Type from the drop-down menu:</p> <ul style="list-style-type: none"> City/Municipality: Select this if the Organization is owned by a City or a Municipality. Corporation: Select this if this is a legal entity that is separate from the people who own it. Shareholders govern the corporation indirectly by electing people to manage it. Federal: Select this if ownership falls within the jurisdiction of the federal government. Indian Health Services: Select this if the ownership falls within the jurisdiction of the Indian Health Services. Limited Liability Corporation: Select this (filing status) if this is a Limited Liability Corporation (LLC). Local Government Agency: Select this if the Organization is owned by a City or a Municipality. Non-Profit: Select this if it is a non-profit enterprise. Partnership: Select this if it is a General Partnership, or a Limited Partnership, where two or more people have created this business entity. State: Select this if the entity is owned by the state in which it operates.
4	<p>Select the checkbox beside the attestation statement: ‘The Business Type entered on this application matches what was reported to the provider’s state business registration entity.’ The provider must review and attest to this statement on all Enrollment, Re-enrollment, MCR, and Re-verification applications when selecting a Business Type.</p>
5	<p>Office Administrator (Authorized Individual): Enter Last Name, First Name, Contact Email, Office Phone #, and User ID (NCID).</p>
6	<p>Effective Date Requested: Enter Effective Date.</p> <p>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. The effective date cannot be more than 90 days in the future.</p> <p>Note: CCNC/CA participation effective date may not be retroactively requested.</p>
7	<p>Select the checkbox beside the attestation statement: ‘I attest that the Requested Effective Date is correct and understand that it cannot be changed once the application is submitted.’</p>
8	<p>Select the Next button to continue.</p>

3.4 INDIVIDUAL BASIC INFORMATION PAGE

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

Note: If additional information is required on enrolling as an OOS Lite or full provider, please refer to Participant User Guide PRV 595 *Out-of-State Provider Enrollment*.

Note: Individual providers who answer **Yes**, and existing providers who change their answer from **No** to **Yes** when answering the question ‘Are you a Rendering/Attending Only provider?’ presented on the **Individual Basic Information** page, cannot participate as Community Care of North Carolina / Carolina ACCESS (CCNC/CA) Primary Care Providers (PCPs). If the Individual provider answers **Yes**, the [CCNC/CA page](#) will not display and ask the provider if they want to enroll as a CCNC/CA PCP.

For all existing active CCNC/CA PCPs who complete an MCR to change their answer from **No** to **Yes** to the question ‘Are you a Rendering/Attending Only provider?’, the page will present the warning: ‘This change will result in the termination of your CCNC/CA participation and your recipients will be reassigned. If you have questions, please contact your local Managed Care Consultant.’

If **Yes** is selected, the provider will not have the opportunity to add EFT information.

If **Yes** is selected, completion of the **Affiliated Provider Information** page will be required. Affiliating to an Organization allows the affiliated Organization to bill and receive payment for the services you have rendered.

Exhibit 7. Individual Basic Information Page #1

Step	Action
1	Identifying Information: Enter Last Name , First Name , Date of Birth , SSN , Gender , NPI , and Email . Note: Individuals should enter their Legal Name (Last, First, and Middle), if applicable.
2	Select the attestation checkbox if you have given your full legal name and you do not have a middle name.

Step	Action
3	Employer Identification Number (EIN): Answer Yes or No to the question: ‘Will your income be reported to an EIN?’ . If Yes , enter EIN . Do not enter the EIN of an Organization or group to which you may be affiliated. Note: DBA information is required when an Individual provider reports their income to an EIN.
4	If Yes is selected for the question ‘Will your income be reported to an EIN?’ , enter DBA Name and Years Doing Business Under This Name . The DBA Name field only allows the following characters: <ul style="list-style-type: none"> • Alpha (A – Z) • Numeric (0 – 9) • Hyphen (-) • Ampersand (&)
5	Rendering/Attending Only Provider: Answer Yes or No to the question: ‘Are you a Rendering/Attending Only provider?’ .
Note	If an Individual provider selects the option to be an OPR Lite provider, they will have fewer pages of the enrollment application to complete. Claims submitted with the NPI of an OPR Lite provider as the billing or rendering provider will not be paid. OPR Lite providers enroll for the sole purpose of ordering, prescribing, and referring products and services for NC Medicaid beneficiaries.

6 Ownership Information: Business Type: -- Select One --

7 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: First Name: Middle Name: Suffix: -- Select One --

Contact Email: SSN: Office Phone #: ext. Office Fax #:

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

8 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. The effective date cannot be more than 90 days in the future.
Note: CCNC/CA participation effective date may not be retroactively requested.

8 Effective Date: mm/dd/yyyy

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

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

Exhibit 8. Individual Basic Information Page #2

Step	Action
6	Ownership Information: Select the Business Type from the drop-down menu. <ul style="list-style-type: none"> • If No was selected for the question ‘Will your income be reported to an EIN?’ in Step 4, select either the Self (Individual Filing Under an SSN) or Sole Proprietor option.

Step	Action
	<ul style="list-style-type: none"> If Yes was selected for the question 'Will your income be reported to an EIN?' in Step 4, select one of the following available options: <ul style="list-style-type: none"> Self – Select this type if you are an Individual filing under an SSN. Single-Owner LLC – Select this type (filing status) if you are an Individual who intends to operate as a sole proprietor and act as the sole owner and manager. Sole Proprietor – Select this type (filing status) if you are an Individual filing under an EIN.
7	Office Administrator (Authorized Individual): Select Same as Enrolling Provider if the Individual provider is the OA. If not selected, the OA is always assumed to be a managing employee. Enter Last Name, First Name, Contact Email, SSN, Office Phone #, and User ID (NCID) .
8	<p>Effective Date Requested: Enter Effective Date.</p> <p>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. The effective date cannot be more than 90 days in the future.</p> <p>Note: CCNC/CA participation effective date may not be retroactively requested.</p>
9	Select the checkbox beside the attestation statement: ' I attest that the Requested Effective Date is correct and understand that it cannot be changed once the application is submitted. '
10	Select the Next button to continue.

3.5 TERMS AND CONDITIONS PAGE

The **Terms and Conditions** page captures the terms and conditions to which you must agree in order to enroll in NCTracks. It also requires that you attest your agreement to the terms and conditions.

3.6 BASIC INFORMATION COMPLETED PAGE

The **Basic Information Completed** page notifies you that the **Basic Information** page has been completed and provides instructions for resuming an In Process application, if you choose.

Note: OPR providers should proceed to [Section 3.9, Ownership Information Page](#).

3.7 PREVIOUS HEALTH PLAN INFORMATION PAGE

The **Previous Health Plan Information** page captures the various past NC DHHS IDs for health plans in which the applicant was enrolled previously.

3.8 HEALTH / BENEFIT PLAN SELECTION PAGE

The **Health / Benefit Plan Selection** page captures applicable health and benefit plans with begin and end dates. Authorized users can update health plan information.

Provider Portal

Welcome, **Vijay Saxena**. (Log out)

Health / Benefit Plan Selection

* indicates a required field

Which NC DHHS Health Plan(s) are you applying for at this time?
What are the qualifications and requirements for the NC DHHS Health Plans?
See [Provider Permission Matrix](#).

DIVISION OF HEALTH BENEFITS, DIVISION OF PUBLIC HEALTH, OFFICE OF RURAL HEALTH

Please select any coverage types for which you wish to enroll by checking the corresponding box.

If you are a Behavioral Health provider intending to contract with a Local Management Entity-Managed Care Organization (LME-MCO), contact the LME-MCO before completing an application in NCTracks. Enrollment in Medicaid does not guarantee a contract with a LME-MCO.

If applying for Medicaid, a \$100 NC Application fee will be required. Upon application submission, you will be directed to Paypoint to make the payment.

Division of Health Benefits (DHB)
☒ Medicaid

Division of Public Health (DPH)
☒ Infant Toddler ☒ Sickle Cell
☒ Early Hearing Detection Intervention ☒ AIDS Drug Assistance Program

Office of Rural Health (ORH)
☒ Migrant Health

Previous Next

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

Save Draft Delete Draft

Exhibit 9. Health / Benefit Plan Selection Page

Step	Action
1	Opt out of any coverage by deselecting the appropriate checkbox: Division of Health Benefits (DHB): Medicaid .
2	Opt out of any coverage by deselecting the appropriate checkbox: Division of Public Health (DPH): Infant Toddler , Sickle Cell , Early Hearing Detection Intervention , and/or AIDS Drug Assistance Program .
3	Opt out of any coverage by deselecting the appropriate checkbox: Office of Rural Health (ORH): Migrant Health .
4	Select the Next button to continue.
Note	If a provider is enrolling as an OPR Lite and/or OOS provider, they will only see DHB health plan: Medicaid .

3.9 OWNERSHIP INFORMATION PAGE

The **Ownership Information** page captures the type(s) of ownership and information about each shareholder/partner with 5% or more ownership as applicable.

The **Ownership Information** page displays only for Organizations and Atypical Organizations if the Business Type (entered/displayed on the [Organization Basic Information page](#)) is Limited Liability Corporation (LLC), Corporation, Non-Profit, or Partnership. An OOS Lite Organization only has access to the **Ownership Information** page when the OA is an owner, and additional owners are not allowed.

Note: Individual providers should continue to the [Addresses page](#).

Ownership Information Legend

* indicates a required field

1 Do you have one or more Shareholders/Partners with 5% or more ownership? **Yes**

2 ☐ Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity, licensure board and Medicare.

3 **SHAREHOLDER/PARTNER INFORMATION**

INDIVIDUAL - SMITH, MICHAEL (AUTHORIZED INDIVIDUAL) --- NEWLY ADDED

Last Name : **smith** First Name : **michael**

Middle Name : **w** Suffix: **-- Select One --**

* Date of Birth: **mm/dd/yyyy** SSN:

* Gender: **-- Select One --**

* Email: * Phone Number:

* Address Line 1:

Address Line 2:

* City:

* State: **--**

* ZIP Code: **00000-0000** Verify Address

* Relationship to Another Disclosing Person: **-- Select One --** * Percent of Ownership/Control Interest: %

4 Add Shareholder/Partner

Please complete the required information for each shareholder/partner with 5% or more ownership.

* This shareholder/partner is:

☐ an individual ☐ a business

5 Save Save Draft Delete Draft

Previous Next

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

Exhibit 10. Ownership Information Page

Step	Action
1	Do you have one or more Shareholders/Partners with 5% or more ownership?: Select Yes or No ; if Yes , the ownership attestation statement and the Shareholder/Partner Information section display.

Step	Action
2	If Yes was selected in Step 1, select the checkbox beside the attestation statement: 'Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity, licensure board and Medicare.'
3	Shareholder/Partner Information: Select the Edit button to edit an existing Shareholder/Partner to change Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Gender, Email, Phone Number, Address, City, State, ZIP Code, Relationship to Another Disclosing Person , and Percent of Ownership/Control Interest . Select the Verify Address button and then the Save button.
4	Add Shareholder/Partner: Select either an individual or a business . <ul style="list-style-type: none"> For an individual, enter Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Gender, Address, City, State, ZIP Code, Relationship to Another Disclosing Person, Percent of Ownership/Control Interest, and Begin Date. Then select the Add button. For a business, enter Business Legal Name, EIN, Address, City, State, ZIP Code, Percent of Ownership/Control Interest, and Begin Date. Then select the Add button.
5	Select the Next button to continue.
Note	OOS Organizations only see the Ownership Information page when the OA is an owner. No other owners can be added to the record.

3.10 ADDRESSES PAGE

The **Addresses** page captures the primary physical location, Pay-To/Remittance Advice (RA), correspondence, and other service location addresses and contact information. Servicing counties are captured for the primary physical location address and for each other servicing address entered.

Note: OPR Lite providers are not required to add additional service locations. Providers must have active participation in Medicare or their home state Medicaid Program for every OOS and border service location entered on the application. If the provider is an OOS or border provider with an OOS or border service location, Credentialing staff will confirm the provider is active with Medicare for each location listed. If not active with Medicare, Credentialing staff will contact the provider's home state Medicaid Program.

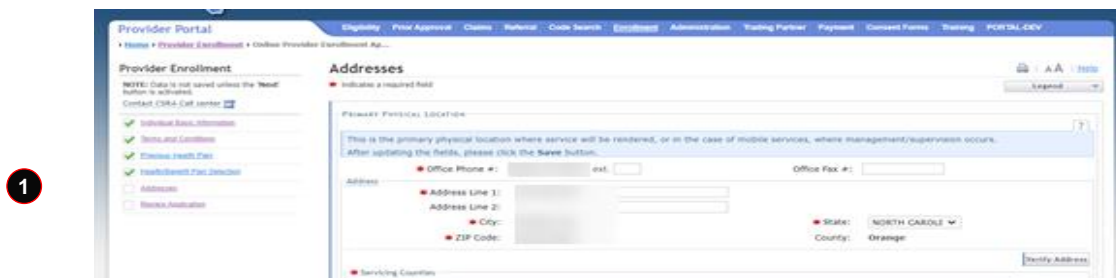


Exhibit 11. Addresses Page #1

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

Exhibit 12. Addresses Page #2

Step	Action
2	Serving Counties: Select all service counties that are contiguous to your primary county from which you will accept CCNC/CA enrollees. For example, if you are located in Wake County, but you accept Managed Care enrollees from Durham County, then check Durham County.
3	1099 Reporting/Pay-To Address: Do you have a separate Pay-To address?: Select Yes or No . Note: All provider records with the same EIN must have the same 1099 Reporting/Pay-To Address. If you need to update the address, submit an MCR application . You need to submit only one application per EIN. Upon application approval, all records with the same EIN will be updated with the new address.
4	Correspondence Address: Do you have a separate correspondence address?: Select Yes or No .

Exhibit 13. Addresses Page #3

Step	Action
5	Service Locations: Add each service location by entering Office Phone # , Address , City , State , and ZIP Code .

6	Select the Add button to add the service location. To add other locations repeat the same steps for each additional service location.
7	Select the Next button to continue.
Note	Additional service locations are not required for OPR Lite providers.

3.11 TAXONOMY CLASSIFICATION PAGE

The **Taxonomy Classification** page allows you to add taxonomy code sets (Provider Type, Classification, and Area of Specialization). Select the taxonomy code(s) under which you will be conducting business with NCTracks for each service location. Taxonomies that are identified as Moderate or High categorical risk levels will have additional enrollment criteria that must be met.

Exhibit 14. Taxonomy Classification Page #1

Step	Action
1	Service Locations: Select the Service Location .
2	Select the Edit Location button.

Exhibit 15. Taxonomy Classification Page #2

Step	Action
3	School Based Health Center: Is your Organization a School Based Health Center (SBHC)?: Select Yes or No .

TYPE, CLASSIFICATION AND AREA OF SPECIALIZATION

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

- * TAXONOMY CLASSIFICATION - 193200000X - MULTI-SPECIALTY
- * TAXONOMY CLASSIFICATION - 282N00000X - GENERAL ACUTE CARE HOSPITAL

4 Add Taxonomy Classification

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

* Provider Type: -- Select One --

* Classification: -- Select One --

* Area of Specialization: -- Select One --

5 Add Clear

Once all taxonomies have been added, click the "Save Location" button to save.

6 Save Location

7

Previous

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

Next »

Save Draft Cancel Enrollment

Exhibit 16. Taxonomy Classification Page #3

Step	Action
4	Add Taxonomy Classification: Using the drop-down menus, select Provider Type , Classification , and Area of Specialization (if applicable).
5	Select the Add button to add another Taxonomy Classification. Note: Repeat this process to add multiple taxonomy codes. You can enter up to 15 taxonomy codes.
6	Select the Save Location button after all taxonomies have been added.
7	Select the Next button to continue.
	Note: As of November 1, 2017, residents and interns licensed through the NC Medical Board with a Resident in Training License (RTL) can also enroll as OPR Lite providers. These practitioners will use the Student Health Care Taxonomy 390200000X. The system will require a license number; the RTL should be used when entering license information. If a resident or intern previously enrolled as an OPR Lite provider and now has credentials to upgrade to a fully enrolled provider, they will need to add their new specialty-specific taxonomy through the MCR process.

3.12 ADD SERVICES AND ENDORSEMENTS PAGE

The **Add Services and Endorsements** page captures services and endorsement information. This page displays only for Organizations and Atypical Organizations with specific taxonomy codes.

Note: This page does not apply to OPR Lite providers.

Add Services and Endorsements

* Indicates a required field

Legend

SERVICE LOCATIONS		
Select	Location	Form Status
		Incomplete
		Incomplete
		Incomplete

To complete information for each service location, select the appropriate location then click the "Edit Location" button.

Edit Location

Exhibit 17. Add Services and Endorsements Page #1

Step	Action
1	Select the Service Location .
2	Select the Edit Location button.

Add Services and Endorsements 4001, DURHAM, NC, 27707-5055

To complete information for this location, fill out this form section then click 'Save Location' in lower right.

TAXONOMY CLASSIFICATION - 251B00000X - CASE MANAGEMENT

Service Type

* Do you wish to add CAP/DA services OR CAP/C services ?

☒ Yes ☐ No

Select Service Type(s)

☒ CAP/DA services ☒ CAP/C services

Which CAP/DA services do you wish to provide for this taxonomy at this location?

CAP/DA SERVICES	
Select	Service Name
<input checked="" type="checkbox"/>	Case Management

Which CAP/C services do you wish to provide for this taxonomy at this location?

CAP/C SERVICES	
Select	Service Name
<input checked="" type="checkbox"/>	Vehicle Modification
<input checked="" type="checkbox"/>	Case Management
<input checked="" type="checkbox"/>	Care Giver Training
<input checked="" type="checkbox"/>	Community Transition Funding

Save Location

Previous Next

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

Exhibit 18. Add Services and Endorsements Page #2

Step	Action
3	Select Service Type: Do you wish to add CAP/DA services OR CAP/C services?: Select Yes or No .
4	Select Service Type(s): CAP/DA (Community Alternatives Program for Disabled Adults) services, CAP/C (Community Alternatives Program for Children) services.
5	Select the checkboxes of services that you plan to render at this location.

6	Select the Save Location button.
7	Select the Next button to continue.

3.13 ACCREDITATION PAGE

The **Accreditation** page allows you to add relevant accreditations, certifications, and licenses.

Based on the location, health plans, and taxonomies that you selected in the application, required accreditation, certification, and/or license fields will be populated. You must complete the remaining required fields.

You can add additional accreditations, certifications, and/or licenses as desired.

Once a Clinical Laboratory Improvement Amendments (CLIA) or Drug Enforcement Agency (DEA) certification is added to a provider record and verified, CSRA will update the effective dates according to information received from those certifying agencies.

Licenses issued by the NC Medical Board for Medical Doctors, Physician Assistants, and Anesthesiologists will also have the effective dates automatically updated once they have been verified as active by CSRA.

Exhibit 19. Accreditation Page #1

Step	Action
1	Add Accreditation: Select Accreditation Type and enter Accreditation # , Effective Date , and Expiration Date . If your accreditation does not have an expiration date, leave this field blank.
2	Select the Add button.
3	Add Certification: Select Certification Type , Certifying Entity , and State and enter Certification # , Effective Date , and Expiration Date . If your certification does not have an expiration date, leave this field blank.
4	Select the Add button.

LICENSES

Taxonomy **237700000X - Hearing Instrument Specialist** requires the following License Type:

- LICENSED AUDIOLOGIST By State Board of Examiners for Speech & Language Pathologists & Audiologists , OR
- LICENSED HEARING AID DEALER & FITTER By State Board of Hearing Aid Dealers and Fitters

- LICENSE - LICENSED HEARING AID DEALER & FITTER BY STATE BOARD OF HEARING AID DEALERS AND FITTERS

License Agency: **State Board of Hearing Aid Dealers and Fitters**
 License Type: **LICENSED HEARING AID DEALER & FITTER**
 State: **NORTH CAROLINA**
 License #: **32185**
 Effective Date: **11/22/2019** Expiration Date: **12/31/2020**

[Delete](#) [Edit](#)

Add License

Select a license type from the drop down list and provide the license number.

5 License Agency: **-- Select One --**
 License Type: **-- Select One --**
 State: **NORTH CAROLINA**
 License #:
 Effective Date: Expiration Date:

6 [Add](#) [Clear](#)

Exhibit 20. Accreditation Page #2

Step	Action
5	Add License: Select License Agency , select License Type , and enter State , License # , Effective Date , and Expiration Date .
6	Select the Add button.

3.14 COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS (CCNC/CA) PAGE

The **Community Care of North Carolina/Carolina ACCESS (CCNC/CA)** page captures providers who want to enroll in CCNC/CA and CCNC/CA contact person information.

3.15 PHYSICIAN EXTENDERS PARTICIPATION PAGE

The **Physician Extenders Participation** page captures participating physician extenders (nurse practitioners, nurse midwives, or physician assistants) and the requested maximum number of CCNC/CA enrollees at the location.

3.16 PREVENTIVE AND ANCILLARY SERVICES PAGE

The **Preventive and Ancillary Services** page captures preventive and ancillary services. This page displays for CCNC/CA applicants only.

3.17 HOURS PAGE

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

3.18 SERVICES PAGE

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

3.19 AGENTS AND MANAGING EMPLOYEES PAGE

The **Agents and Managing Employees** page captures managing relationships. A managing relationship is between the provider and an employee (i.e., general manager, business manager, administrator, director, or other person who exercises operational or managerial control of a provider, or who directly or indirectly conducts the day-to-day operations of a provider).

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.

1 Does the applicant have any agent(s) and/or managing employee(s)? **Yes**

Managing Relationships

Please add all managing relationships below.

2 **+ 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:

Verify Address

3 Add Clear

Exhibit 21. Agents and Managing Employees Page

Step	Action
1	Relationship Disclosure: Does the applicant have any agent(s) or managing employee(s)? Select Yes or No ; if Yes , the Managing Relationship section displays.
2	In the Add Relationship section: <ul style="list-style-type: none"> Complete the fields Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Email, Phone Number, Business Relationship, Address, City, State, and ZIP Code. If applicable, select the attestation checkbox: 'I attest that I have entered the full legal name of the individual, and the individual does not have a middle name.' Select the Verify button.
3	Select the Add button to continue.

3.20 HOSPITAL ADMITTING PAGE

The **Hospital Admitting** page captures Hospital Admitting information for Individual providers.

Note: This page does not apply to OPR Lite providers.

The screenshot shows the 'Hospital Admitting' page. At the top, there's a title bar with 'Hospital Admitting', a printer icon, 'AA', and a 'Help' link. Below the title bar, a legend indicates that an asterisk (*) denotes a required field. The main form area is titled '* HOSPITAL ADMITTING PRIVILEGES'. Step 1 points to the question 'Does the enrolling provider have hospital admitting privileges?' with radio buttons for 'Yes' and 'No'. Step 2 points to the '* County:' dropdown menu, which is currently set to 'DURHAM'. Step 3 points to the '* Hospital(s):' section, which includes an 'Available Options' list on the left (SELECT SPECIALTY HOSPITAL DURH, DUKE UNIVERSITY HOSPITAL, DURHAM REGIONAL HOSPITAL) and a 'Selected Options' list on the right (NORTH CAROLINA SPECIALTY HOSPI). Between these lists are buttons for 'Add >', 'Add All >', '< Remove', and '< Remove All'. Step 4 points to the 'Add' button at the bottom right of the hospital selection area. Step 5 points to the 'Next >>' button at the bottom right of the page. A 'Previous <<' button is at the bottom left. A footer note states: 'Please be sure to complete all required fields with valid content.'

Exhibit 22. Hospital Admitting Page

Step	Action
1	Does the enrolling provider have hospital admitting privileges?: Select Yes or No . Select Yes to add hospital(s).
2	Select the County in which the hospital is located.
3	Hospitals: Select the hospitals to which you have admitting privileges from the Available Options list on the left side of the page. Once the hospitals have been selected, select the Add> button to move them to the Selected Options list to the right. Note: You can select multiple hospitals in a County by holding down the CTRL key while selecting each hospital.
4	Select the Add button to save the hospital selections.
5	Select the Next button to continue.

3.21 PHARMACY INFORMATION PAGE

The **Pharmacy Information** page captures pharmacy information and pharmacy manager information. This page displays for pharmacy providers only.

Note: This page does not apply to OPR Lite providers.

3.22 FACILITIES INFORMATION PAGE

The **Facilities Information** page allows you to edit/respond to teaching hospital questions and bed accommodations types.

Note: This page does not apply to OPR Lite providers.

3.23 METHOD OF CLAIM AND ELECTRONIC TRANSACTIONS PAGE

The **Method of Claim and Electronic Transactions** page captures how you will be submitting and/or receiving electronic transactions.

Note: This page does not apply to OPR Lite providers.

Note: Abbreviated MCR applications allow providers to add/update their method of claim and electronic transactions. For more information, refer to [Section 4](#) and to Participant User Guide PRV 563 *Abbreviated Managed Change Request*. Users with the Enrollment Specialist user role can submit all Abbreviated MCRs except EFT. The OA and Owner/Managing Employee users can submit all Abbreviated MCRs including the EFT Abbreviated MCR.

3.24 ASSOCIATE BILLING AGENT PAGE

The **Associate Billing Agent** page captures associated Billing Agent(s) information. If you use a Billing Agent, you must report the Billing Agent.

Note: This page does not apply to OPR Lite providers.

3.25 AFFILIATED PROVIDER INFORMATION PAGE

During the Initial Enrollment process, a provider can add an affiliation to an Organization whose overall status is active, terminated, or suspended, as well as affiliate to an Organization's location that is active or end-dated. The effective begin date of any affiliation will be set to the most recent Enrollment Effective Date. If the Organization's Enrollment Effective Date is the most recent, that will be the affiliation's Begin Date. If the Individual provider's Enrollment Effective Date is the most recent, that will be the date of the affiliation.

The **Affiliated Provider Information** page captures information on the Organization(s) to which an applicant wants to affiliate. Individual providers who answered **Yes** to the question 'Are you a Rendering/Attending Only provider?' on the **Basic Information** page will be required to complete this page during the Initial Enrollment process.

Note: This page does not apply to OPR Lite providers.

Note: Abbreviated MCR applications allow providers to add/update affiliations. For more information on the Abbreviated MCR options, refer to [Section 4](#) and to Participant User Guide PRV 563 *Abbreviated Managed Change Request*. Users with the Enrollment Specialist user role can submit all Abbreviated MCRs except EFT. The OA and Owner/Managing Employee users can submit all Abbreviated MCRs including the EFT Abbreviated MCR.

If the Organization participates in CCNC/CA, the enrolling provider will be given an option to participate in CCNC/CA under the group. In this example, the affiliating group does not participate in CCNC/CA, so 'N/A' is present.

Individual providers who answered **No** to the same questions can affiliate themselves to a Billing Agent.

Affiliated Provider Information

* Indicates a required field

Legend

1 *** AFFILIATED PROVIDER INFORMATION**
Do you wish to link or affiliate with another enrolled provider?
Select Yes if you wish to identify one or more organizations who may bill and may be paid for services you have rendered.
☒ Yes ☐ No

AFFILIATED PROVIDERS
The affiliation allows this organization to bill and receive payment on your behalf.
Add Affiliated Provider

Enter organization's NPI and click 'Lookup NPI'.

* NPI: **2** **Lookup NPI**

Organization Name:

Enrollment Effective Date:

* Please select locations of affiliated provider.
Select box next to the location(s) you wish to affiliate and click 'Add'.

Location	Do you wish to participate in CCNC/CA under this group?
<input type="checkbox"/> <input type="text"/>	N/A

3 **Add** **5**

6 **Next**

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

((Previous Next))

Select box next to the location(s) you wish to affiliate and click 'Add'.

Location	Do you wish to participate in CCNC/CA under this group?
<input type="checkbox"/> <input type="text"/>	4 <input type="radio"/> Yes <input type="radio"/> No

Add

Exhibit 23. Affiliated Provider Information Page

Step	Action
1	Affiliated Provider Information: Do you wish to link or affiliate with another enrolled provider?: Select Yes or No .
2	NPI: Enter the NPI of the Organization or group to which you want to affiliate. Select the Lookup NPI button.
3	Select the location(s) to which you want to affiliate.
4	Do you wish to participate in CCNC/CA under this group at this location?: Select Yes or No . Note: If the Organization to which you are affiliating does not participate in CCNC/CA, 'N/A' will be present.
5	Select the Add button to save the Affiliation.
6	Select the Next button to continue.
Note	If a claim is pended due to Affiliation Claim Edit 07025 (Rendering Provider Not Affiliated with Billing Provider) and an affiliation is not added or updated within 60 days, the claim will deny.

3.26 EFT ACCOUNT INFORMATION PAGE

The **EFT Account Information** page captures EFT and Remittance information. All payments are by EFT in NCTracks.

Note: This page does not apply to OPR Lite providers.

3.27 PROVIDER SUPPLEMENTAL INFORMATION PAGE

The **Provider Supplemental Information** page captures the provider's work history, education, and current malpractice insurance information.

Provider Supplemental Information

* indicates a required field

Legend

1 **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: mm/dd/yyyy * End Date: mm/dd/yyyy

Add

2 **EDUCATION**

Enter your highest level of education completed.

Add Education History

* School Name: * Degree:

* Start Date: mm/dd/yyyy * Graduate Date: mm/dd/yyyy

Add

3 **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

Previous Next

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

Save Draft Delete Draft

Add Malpractice

* Malpractice type: -- Select One --

* Effective Date: mm/dd/yyyy * Expiration Date: mm/dd/yyyy

Add

Exhibit 24. Provider Supplemental Information Page

Step	Action
1	<p>Work History: Enter your work history as a health professional for the past 5 years. It is not necessary to provide any work history prior to the 5-year timeframe.</p> <p>If there is a gap in the Individual provider's work history of 6 months or more, the provider is required to upload written documentation explaining any gaps that occurred in the past 5 years.</p> <ul style="list-style-type: none"> Company Name: Employer name Job Title: Position/job title

Step	Action
	<ul style="list-style-type: none"> • Start Date: Start date of the job title at this company • End Date: End date of the job. If you still hold this job title at this company, enter 12/31/9999. <p>Note: When entering work history, if the enrolling provider is currently a resident or intern, he/she should enter the details of that residency/internship such as:</p> <ul style="list-style-type: none"> • Company Name: Healthcare Facility XYZ • Job Title: Resident • Start Date: Date residency/internship began • End Date: 12/31/9999 if still a resident/intern
2	<p>Education: Enter your Education information.</p> <ul style="list-style-type: none"> • School Name: School or institution name • Degree: Highest degree • Start Date: Date started at the school or institution • Graduate Date: Date graduated from the school with this degree
3	<p>Current Malpractice Insurance Coverage:</p> <ul style="list-style-type: none"> • Do you have malpractice insurance or are you covered under a federal tort?: Select Yes if you have malpractice insurance or are covered under a federal tort. • Malpractice Type: Select the type of malpractice coverage • Amount: Enter the amount of malpractice coverage • Effective Date: Effective date of the coverage • Expiration Date: Expiration date of the coverage

3.28 EXCLUSION SANCTION INFORMATION PAGE

Welcome, ' (Log out)
NCTracks Help

Eligibility Prior Approval Claims Referral Code Search Enrollment Administration Trading Partner Payment Consent Forms Training

Provider Enrollment Ap...

Exclusion Sanction Information
Legend

* Indicates a required field

EXCLUSION SANCTION INFORMATION

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

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

For each exclusion sanction 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 in addition to a written explanation of the supporting documentation.

- A thorough written explanation signed by the subject of the offense if an individual or by the provider's Office Administrator if the subject of the offense is an organization of the occurrence and dated within 6 months of the application date, by the provider's Office Administrator, an owner or managing employee of the occurrence including references to the infraction/conviction date(s) entered and the resolution.
- All supporting documentation (See Job Aid/FAQ) that relates to the incident.

Failure to submit all of the request information may result in the application being deemed incomplete.

Exclusion Sanction Supporting Documentation Job Aid/FAQ

1

- * 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
- * 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 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 has 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
- * L. Has the enrolling provider had any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from coverage?
☐ Yes ☐ No
- * M. Has the enrolling provider ever practiced without liability coverage?
☐ Yes ☐ No
- * N. Does the enrolling provider have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position?
☐ Yes ☐ No
- * O. Has the enrolling providers hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending?
☐ Yes ☐ No
- * P. Has the enrolling provider had a professional liability claim assessed against them in the past five years or are there any professional liability cases pending against them?
☐ Yes ☐ No

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

Exhibit 25. Exclusion Sanction Information Page

Step	Action
1	<p>Select Yes or No for each Exclusion Sanction question. When Yes is selected for a question, the Infraction/Conviction Dates section displays. Select the Add button to add an Infraction/Conviction Date.</p> <p>For each question answered Yes, you must attach or submit a complete copy of the applicable criminal complaint or disciplinary action, Consent Order, documentation regarding recoupment/repayment settlement action, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application.</p> <p>Disclosure of adverse legal actions may not preclude participation with the NC Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the NC Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).</p> <p>Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p> <p>New questions have been added, so be sure to read each question carefully.</p>

3.29 FEDERAL REQUIREMENTS PAGE

The **Federal Requirements** page displays when the application requires a Federal Site Visit or payment of the Federal Fee. When the provider is moderate or high risk, the Federal Site Visit and/or Fee is required. Providers are identified as moderate or high risk according to the Provider Permission Matrix, which can be found on the [Provider Enrollment page](#) of NCTracks.

The **Federal Site Visit** section of the page displays when the location requires a Federal Site Visit. The **Federal Fee** section displays when the location requires the Federal Fee.

Note: As of the current Provider Permission Matrix, the NEMT (Non-Emergency Medical Transportation) taxonomy requires both the Federal Site Visit and payment of the Federal Fee.

Federal Requirements

* Indicates a required field

Legend

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?

1

MEDICARE

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?

2

OTHER STATE

* Other State:

FLORIDA

3

Previous

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

Next

Exhibit 26. Federal Requirements Page

Step	Action
1	<p>Answer the question: ‘Have you completed the Federal site visit for this site to NC Medicaid, another state or Medicare?’.</p> <ul style="list-style-type: none"> Select NO if you have not completed a Federal Site Visit for this location with either another state or Medicare. Select MEDICARE if completed with Medicare. Select OTHER STATE if completed for another state Medicaid program. Note: If you select NO, Public Consulting Group (PCG) will contact you after the application has been submitted to set up the site visit. If you select MEDICARE, CSRA will confirm the site visit completion with Medicare. If you select OTHER STATE, you are required to upload proof of completion as part of the application submission. <p>Note: When a taxonomy requiring a site visit is added or reinstated to a new, reinstated, or existing location, NCTracks will present the Federal Requirements/Site Visit Completed question only if the provider has not completed a site visit within the past 5 years. Providers will not be required to complete a site visit if a site visit has been completed for the service location within the past 5 years.</p>
2	Other State: If applicable, select the state.
3	<p>Answer the question: ‘Have you paid the Federal Fee for this site to NC Medicaid, another state or Medicare?’.</p> <ul style="list-style-type: none"> Select NO if you have not paid a Federal Fee for this location with either another state or Medicare. Select MEDICARE if paid to Medicare. Select OTHER STATE if completed for another state Medicaid program. Note: If you select NO, upon submission of this application, you will be directed to PayPoint to pay the fee. If you select MEDICARE, CSRA will confirm the payment was made with Medicare. If you select OTHER STATE, you are required to upload proof of payment as part of the application submission.

Step	Action
	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, regardless of how many of the provider's service locations require the fee.
4	Select the Next button to continue.

3.30 REVIEW APPLICATION PAGE

Selecting the **Review Application** button displays a window that will allow you to open a PDF file of your application, which you can print and review for accuracy before submitting.

Review Application

| A- A+ | [Help](#)

ELECTRONIC SIGNATURE - EMAIL CONFIRMATION

- Please confirm that the email address below is correct. If you don't already have one, an **Electronic Signature PIN** will be sent to this address upon submitting the next page. You will need access to this email address to retrieve/reset your PIN and complete this Online Application.
- If the email below is incorrect, you may now navigate back to the [Basic Information page](#) to update it. (Remember to click 'Next' on the [Basic Information page](#) to store your change.)

Contact Email: **abc@123.com**

REVIEW APPLICATION

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

1

Review Application

« Previous

2 Next »

Application Last Updated: 2009-11-22

Cancel Enrollment

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

Exhibit 27. Review Application Page

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

3.31 SIGN AND SUBMIT ELECTRONIC APPLICATION PAGE

The **Sign and Submit Electronic Application** page allows you to electronically sign the application. It lists additional required documents with an option to electronically upload and attach them to the application.

Sign and Submit Electronic Application

* Indicates a required field

If for any reason you navigate away from this page without clicking 'Submit Now', you will be required to re-enter the information.

ELECTRONIC SIGNATURE CONFIRMATION

Attestation: I have read and agreed to the terms and conditions of participation. By submitting this form, I confirm the information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this electronic document is submitted. I do hereby attest that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

1 * Login ID (NCID): [Forgot Login ID](#)

2 * Password: [Forgot Password](#)

- If this is your first Provider Enrollment submission, your Electronic Signature PIN has now been sent to @csc.com. Please retrieve it now to complete submission. If the email is incorrect, you may now navigate back to the Basic Information page to update it. (Remember to click Next on the Basic Information page 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 by entering you Login ID (NCID) and Password and clicking the 'Forgot PIN' link. The PIN will be sent to your email address.

Please contact the CSRA Call Center at 800-688-6696 if you have any trouble with your Electronic Signature PIN Number.

3 * PIN: [Forgot PIN](#)

4 Please review the documents you are going to electronically sign.

- [Trading Partner Agreement](#)
- [Agreement and Attestations](#)

REQUIRED ATTACHMENTS

3301 Dr, RALEIGH, NC 27609-7362

Your application indicates that you are enrolling as:

- RESPIRATORY, DEVELOPMENTAL, REHABILITATIVE AND RESTORATIVE SERVICE PROVIDERS, Physical Therapist, None

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

ONLINE APPLICATION SUBMISSION

You may now submit your Online Application by clicking 'Submit Now' below. After submitting you will have the option to print a copy of the completed application for your records.

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.

5

Exhibit 28. Sign and Submit Electronic Application Page

Step	Action
1	Enter User ID .
2	Enter Password .
3	Enter PIN .
4	Select the Trading Partner Agreement and/or Agreement and Attestations links to review each.
5	Select the Submit Now or Submit Later buttons to submit.

3.32 APPLICATION SUBMISSION STATUS PAGE

Application Submission Status

APPLICATION SUBMISSION STATUS:

Application submission is in progress. Please do not click Browser Back and/or Refresh button.

Submitting Application completed ✓

Preparing Application/Agreement PDFs completed ✓

Uploading PDFs completed ✓

Provider Portal

Eligibility | Prior Approval | Claims | Referral | Code Search | **Enrollment** | Administration | Trading Partner | Payment | Consent Forms | Training | PORTAL-DEV

Home > Provider Enrollment

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

Quick Links

[Online Application](#)
[Advanced Medical Home Tier Attestation](#)
[Health Information Exchange \(HIE\) Status](#)
[Provider Enrollment Users](#)

Application Submission Status

APPLICATION SUBMISSION STATUS:

Application submission is in progress. Please do not click Browser Back and/or Refresh button.

Submitting Application completed ✓

Preparing Application/Agreement PDFs completed ✓

Uploading PDFs completed ✓

Exhibit 29. Application Submission Status Page

Note: The **Application Submission Status** page will display while your application is submitting. Do not select **Back** or **Refresh**. Wait for the display of three green check marks to know your application has been submitted successfully.

3.33 FINAL STEPS PAGE

The **Final Steps** page informs you that the application submission is complete. This page also contains the final steps you must take in order to complete the application process (supplemental documents required). You can also download a PDF copy of the submitted application. If a provider is required to complete the fingerprinting process as identified in the Provider Permission Matrix, they will be notified on this page.

If the application is deemed incomplete or if additional information is required, the provider will receive a notification letter indicating that they will have 30 days to submit the required information or the application will be abandoned. If documentation is received timely but is inadequate, the provider will be notified and given an additional 10 days to submit the required information. If the information is received and reviewed and it is still inadequate, the provider will be notified and given an additional 10 days. If the correct information is not received the third time, the application will be abandoned and the provider will have to resubmit the application. If

no documentation is received after the first 30-day notice or either of the 10-day notices, the application will be abandoned.

The OA/ES user will have access to the notification letters via the Message Center inbox as well as a hyperlink on the **Status and Management** page.

If the application is denied, the notification letter will be sent via e-mail.

Provider Portal

Welcome, Vijay Saxena. (Log out)

NCTracks Help

Eligibility | Prior Approval | Claims | Referral | Code Search | **Enrollment** | Administration | Trading Partner | Payment | Consent Forms

Home | **Provider Enrollment** | Online Provider Enrollment Ap...

Provider Enrollment

Contact CSRA Call center

Final Steps

* indicates a required field

Legend

1 ONLINE SUBMISSION COMPLETE

Thank you for submitting the online portion of your application.
Please save/print the following documents for your records

- Online Application
- Cover Sheet
- Review Agreement

Now that you have submitted your online application, you will not be able to retrieve the application or reprint application documents.

2 APPLICATION FEE REQUIRED

Thank you for applying to Medicaid. In order to complete your application, a NC Application Fee is required. Please click the "Pay Now" button. You will be directed to Paypoint to make the payment.

3 FINGERPRINTING REQUIRED

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

4 REQUIRED ATTACHMENTS

For each exclusion sanction 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 in addition to a written explanation of the supporting documentation.

- A thorough written explanation signed by the subject of the offense if an individual or by the provider's Office Administrator if the subject of the offense is an organization of the occurrence and dated within 6 months of the application date, by the provider's Office Administrator, an owner or managing employee of the occurrence including references to the infraction/conviction date(s) entered and the resolution.
- All supporting documentation (See Job Aid/FAQ) that relates to the incident.

Failure to submit all of the request information may result in the application being deemed incomplete.
Exclusion Sanction Supporting Documentation [Job Aid/FAQ](#)

5 ELECTRONIC ATTACHMENTS

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

*** REQUIRED SUPPLEMENTAL DOCUMENTS**

In order to complete your application, you must print, complete, and sign the required [NC DHHS Health Check Agreement between Primary Care Provider \(PCP\) and the Local Health Department](#). Your application will not be considered complete until CSRA receives the agreement.

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

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

Exhibit 30. Final Steps Page

Step	Action
1	Print/save the Online Application and/or Cover Sheet . This will be the only opportunity to save, download, or print the PDFs.
2	Select the Pay Now button. The PayPoint landing page displays. See Addendum B to view the PayPoint process. Note: Application Fee Required: A \$100 NC Application Fee is required when applying for Medicaid, except for OOS Lite providers.
3	Fingerprinting Required: This section will display if the application requires fingerprinting.
4	Required Attachments: Review the list of documents that need to be included with the application.
5	Select the Upload Documents button.

3.33.1 Upload Documents Page

The **Upload Documents** page allows you to upload any additional relevant documents associated with a submitted application.

Upload Documents AA [Help](#)

* Indicates a required field

Legend

Electronic Attachments

Only one file can be uploaded at a time. Maximum 20 files can be uploaded per application. A File cannot be more than 25 MB.
The following file types may be attached: MS-Word, MS-Excel, WordPerfect, MS-Write, Open Office, text, Power Point, Zip, PageMaker, Adobe PDF, image(TIFF, JPEG, GIF, PNG).
To upload a file:
1. Click the Browse button.
2. Locate the file and add. Note: The file name will display to the right of the Browse button.
3. Click the Upload Document button to submit the file to NCTracks.
4. When upload is successful, a message will be displayed with the file name. If you wish to print a record of submitted attachments, click the printer icon located at the right hand corner of the screen.

For each exclusion sanction 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 in addition to a written explanation of the supporting documentation.

1. A thorough written explanation signed by the subject of the offense if an individual or by the provider's Office Administrator if the subject of the offense is an organization of the occurrence and dated within 6 months of the application date, by the provider's Office Administrator, an owner or managing employee of the occurrence including references to the infraction/conviction date(s) entered and the resolution.
2. All supporting documentation (See Job Aid/FAQ) that relates to the incident.
Failure to submit all of the request information may result in the application being deemed incomplete.
Exclusion Sanction Supporting Documentation [Job Aid/FAQ](#)

Uploaded Documents

Uploaded File(s)

.pdf

General Enrollment Additions

Upload general enrollment documents related to the application here. Do not upload fingerprinting documents here. Maximum 20 files can be uploaded per application.

1 Choose File No file chosen 2 Upload Document

Fingerprint Evidence Documents

Upload a copy (copies) of your completed fingerprinting evidence form(s) here. Maximum 20 files can be uploaded per application.

3 Choose File No file chosen 4 Upload Document

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

Exhibit 31. Upload Documents Page

Step	Action
1	Select the Browse button under the General Enrollment Additions section to upload general documents. Note: The file name will display to the right of the Browse button.
2	Select the Upload Document button to submit the file to NCTracks.

Step	Action
3	Select the Browse button to locate the completed Fingerprinting Evidence Form. Note: The file name will display to the right of the Browse button.
4	Select the Upload Document button to submit the file to NCTracks.

You will receive an 'Upload Successful' message upon a successful upload of additional documents. The message will also display the filename that was successfully uploaded. If you want to print a record of submitted attachments, select the printer icon located in the upper right corner of the page.

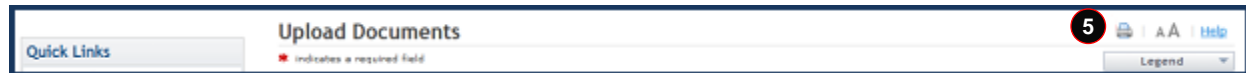


Exhibit 32. Upload Documents Page – Printer Icon

Step	Action
5	Select the printer icon to print a record of submitted attachments.

3.34 STATUS AND MANAGEMENT PAGE

The **Status and Management** page displays categories of applications. The 'Status' column of the **Submitted Applications** section may also provide hyperlinks to allow the user to upload documents, withdraw applications that are still in review, or review notification letters if the application has been returned due to additional information being required. Notification letters will be available for review from the **Status and Management** page as well as the Message Center inbox. Notification letters for Initial Enrollment applications will only be delivered to the OA's e-mail address.

If the information (Name, DOB, SSN, or EIN) submitted on the application is incorrect and does not match our findings during the background check, CSRA will return the application and send the OA an Application Incomplete letter. When the **Returned** hyperlink is selected, the provider will be redirected to the Application Incomplete letter, which will contain details of the incorrect information received. After reviewing the incorrect information indicated in the letter, if the provider agrees that the information is incorrect, the OA should navigate to the **Status and Management** page and withdraw the application. The provider may also respond to the Application Incomplete letter advising that the information is incorrect and requesting CSRA to withdraw the application. If CSRA withdraws the application, the Application Withdrawal letter is sent to the Message Center inbox. Withdrawal letters for Initial Enrollment applications will be sent to the OA's e-mail address.

Applications withdrawn by CSRA or the provider will have a 'Withdrawn' status in the **Submitted Applications** section of the **Status and Management** page. CSRA-withdrawn applications will always be accompanied by a withdrawal letter. Providers do not receive correspondence when the withdrawal is completed in the Provider Portal.

Note: While inaccurate data is the example provided for the application withdrawal process, a provider can withdraw an application for any reason deemed necessary.

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.

1 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.

NPI/Atypical ID	Name	DBA Name	Application Type	Submit Date	Status
			ENROLLMENT	03/20/2019	Withdraw, Pay Now, Upload Documents - Payment Pending
			RE-VERIFICATION	03/20/2019	Withdrawn
			RE-VERIFICATION	01/09/2019	Withdrawn
			ABBREVIATED AFFILIATIONS MANAG	12/20/2018	Manage Change Request Complete
			MANAGE CHANGE REQUEST	10/26/2018	Withdraw, Upload Documents - Returned

2 SAVED APPLICATIONS

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.

Select	NPI/Atypical ID	Name	ZIP Code	Application Type	Application Create Date	Last Saved
<input type="radio"/>				Re-verification	02/11/2011	02/11/2011
<input type="radio"/>				Manage Change Request	02/11/2011	02/11/2011

3 RE-ENROLL

The following provider accounts associated with your NCID have been terminated. Please select the account with which you would like to re-enroll, then click 'Submit'.

Select	NPI/Atypical ID	Name	ZIP Code	Termination Date
<input type="radio"/>			27609-4916	01/25/2011
<input type="radio"/>			27607-3073	01/25/2011

Exhibit 33. Status and Management Page #1

Step	Action
1	<p>Submitted Applications: Allows you to view the status of a submitted provider enrollment application.</p> <ul style="list-style-type: none"> • 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 hyperlink 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. • MCR Comp (Manage Change Request Complete): You requested a change that does not require review; therefore, this change was instantly completed. • ME Comp (Maintain Eligibility Complete): Your Maintain Eligibility does not require review; therefore, this request was instantly completed. • 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.
2	Saved Applications: Allows you to resume a saved provider enrollment application.
3	Re-enroll: Allows you to re-enroll a terminated provider enrollment account.

4

MANAGE CHANGE REQUEST

If you are a behavioral health provider contracted with a Local Management Entity/Managed Care Organization (LME/MCO) and you update your data in a NCTracks Manage Change Request application, please ensure your LME/MCO has the same updated data on file.

The following provider accounts associated with your NCID are active. Please select the account with which you would like to submit a Manage Change Request, then click 'Update'.

Select	NPI/Atypical ID	Name	DBA Name	ZIP Code	Begin Date	Status
<input type="radio"/>				27607-0028	02/06/2017	Active
N/A				27406-1398	04/01/2008	Active
N/A				28210-8509	12/01/1981	Active
<input type="radio"/>				27610-1808	11/20/1973	Active

Update

5

RE-VERIFICATION

The following provider accounts associated with your NCID require a Reverification Application to be completed by the due date indicated. Please select the record with which you would like to proceed, then click 'Submit'.

Select	NPI/Atypical ID	Name	DBA Name	ZIP Code	Due Date
<input type="radio"/>				27610-1808	04/01/2018

Re-Verify

6

MAINTAIN ELIGIBILITY

NO DATA FOUND

7

FINGERPRINTING REQUIRED

NO DATA FOUND

Exhibit 34. Status and Management Page #2

Step	Action
4	Manage Change Request: Allows you to submit an MCR application for an active provider enrollment account.
5	Re-verification: Allows you to submit a required Re-verification application for a provider enrollment account.
6	Maintain Eligibility: Allows you to submit a required Maintain Eligibility application for a provider enrollment account.
7	Fingerprinting Required: Allows you to submit a Fingerprinting Required application for the NPI or Atypical number.

3.34.1 Status and Management Page – Select Pagination

On October 11, 2020, the **Status and Management** page was updated for authorized users (OAs, ES users, and managing employees/owners) who have access to more than 50 NPIs.

Note: This change does not affect users who have access to 50 or fewer NPIs.

Exhibit 35. Status and Management Page – Select Pagination

Providers with access to more than 50 NPIs can use the **Select Page** filter in the **Select Pagination** section of the **Status and Management** page to display NPIs in the **Submitted Applications**, **Manage Change Request (MCR)**, **Re-enroll**, **Re-verification**, and **Fingerprinting** sections by selecting the page that corresponds to the NPI requested. The NPIs will be in numerical order and each page will consist of 50 NPIs.

This Page Intentionally Left Blank

4.0 Manage Change Request

4.1 STATUS AND MANAGEMENT PAGE

The user may need to update information on the provider record such as effective begin dates, EFT, taxonomy, address, affiliations, licensure, or change from an OOS/OPR Lite to a full provider. These changes would require an MCR.

For more information on requesting to backdate effective dates on a provider record, please refer to Job Aid PRV 702 *Request to Backdate Enrollment Effective Dates*.

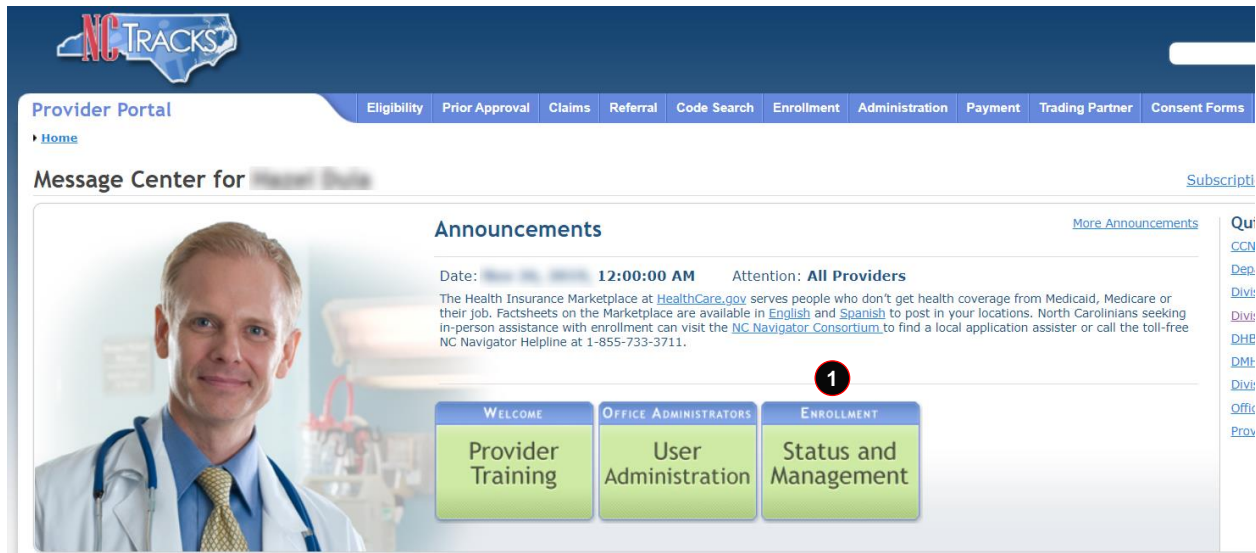


Exhibit 36. Provider Portal Home Page

Step	Action
1	From the secure Provider Portal Home page, select the Status and Management button. The Status and Management page displays. To begin an MCR application, scroll down to the Manage Change Request section.

MANAGE CHANGE REQUEST

The following provider accounts associated with your NCID are active. Please select the account with which you would like to submit a Manage Change Request, then click 'Update'.

Select	NPI/Atypical ID	Name	ZIP Code	Begin Date	Status
<input type="radio"/>			27502-0000	12/05/2012	Active
<input type="radio"/>			27502-1216	02/01/2013	Active
<input type="radio"/>			27707-5055	03/01/2013	Active
<input type="radio"/>			27502-1216	12/26/2012	Active
<input type="radio"/>			27502-1216	12/28/2012	Active
<input type="radio"/>			27502-1215	12/01/2012	Active
<input type="radio"/>			27409-2027	03/20/2006	Active
<input type="radio"/>			27522-8297	12/06/2000	Active
<input type="radio"/>			27577-3933	08/01/2007	Active
<input type="radio"/>			27105-1332	01/01/1988	Active
<input type="radio"/>			27502-5316	02/05/2007	Active

Update

Exhibit 37. Status and Management Page – Manage Change Request Section

Step	Action
1	Select the radio button next to the record for which you want to begin an MCR application.
2	Select the Update button.

4.2 REQUESTED MANAGE CHANGE REQUEST TYPE PAGE

When the OA, an Owner/Managing Employee user, or an ES user selects the **Update** button on the **Status and Management** page, they will be directed to the **Requested Manage Change Request Type** page.

Requested Manage Change Request Type

* Indicates a required field

Legend

MANAGE CHANGE REQUEST TYPE

Select the type of Manage Change Request you would like to complete.

NPI/Atypical ID:

Name:

ORGANIZATION PROVIDERS

☐ BACK-DATING - ABBREVIATE MANAGE CHANGE REQUEST
Provider back-dating¹

☐ EFT - ABBREVIATE MANAGE CHANGE REQUEST
Update Electronic Funds Transfer (EFT) Account Information¹

☐ METHOD OF CLAIM, ELECTRONIC TRANSACTIONS - ABBREVIATE MANAGE CHANGE REQUEST
Add/Update Method of Claim and Electronic Transactions and/or Billing Agent Information¹

☒ MANAGE CHANGE REQUEST
Complete multiple changes or review your complete provider record

¹Please have all information available, this application must be completed in one session.

Next >>

Exhibit 38. Requested Manage Change Request Type Page

Step	Action
1	<p>Manage Change Request Type: Select one of the following options:</p> <ul style="list-style-type: none"> • Update Electronic Funds Transfer (EFT) Account Information: Select this option to update provider EFT bank account information. If you do not see this option: <ul style="list-style-type: none"> – The provider is listed in NCTracks as an individual provider who is rendering/attending only. – The provider is listed in NCTracks as OPR Lite. – The NCID is not the OA's NCID for the provider. • Add/Update Affiliations: Select this option if you are an individual provider and wish to add or end-date an affiliation to an organization/group. The affiliation process allows a group or organization to bill and receive payments on behalf of an individual/rendering provider. Please have affiliation information available; this application must be completed in one session. Note: The Add/Update Affiliations option displays only when the provider is an individual provider. • Add/Update Method of Claim and Electronic Transactions and/or Billing Agent Information: Select this option if you wish to change how you will be submitting/receiving claims and electronic transactions OR if you wish to add or end-date your association with a billing agent. If you do not see this option, you are listed in NCTracks as an individual provider who is rendering/attending only. To change your status, you will need to complete a full MCR. Select Complete multiple changes or review your complete provider record to complete a full MCR. Please have information available; this application must be completed in one session. • Complete multiple changes or review your complete provider record: Select this option if you wish to make any update not listed. When you select this option, you will complete a full MCR application.
2	Select the Next button to continue.
Note	For more information on the Abbreviated MCR options, refer to Participant User Guide PRV 563 <i>Abbreviated Managed Change Request</i> .

Requested Manage Change Request Type

* indicates a required field

MANAGE CHANGE REQUEST TYPE

Select the type of Manage Change Request you would like to complete.

NPI/Atypical ID:

Name:

Provider Lite Type: ORDERING, PRESCRIBING, REFERRING PROVIDERS ENROLLED WITH THE LITE APPLICATION

INDIVIDUAL PROVIDERS

☐ BACK-DATING - ABBREVIATE MANAGE CHANGE REQUEST

Provider back-dating1

☐ **UPGRADE TO FULL PROVIDER**

Complete multiple changes or review your complete provider and change provider from lite to full. With the implementation of Section 6405 of the Affordable Care Act, CMS requires certain physicians and non-physician practitioners to enroll in the Medicaid program for the sole purpose of ordering, referring, or prescribing items or services for Medicaid beneficiaries (42 CFR 455.410). You are currently enrolled as an OPR provider. Select this option if you wish to switch from an OPR provider to a billing, rendering, or attending provider.

☒ **CONTINUE AS LITE PROVIDER APPLICATION**

Complete multiple changes or review your complete provider record

Next »

Exhibit 39. Requested Manage Change Request Type for OPR Page

Step	Action
1	An OPR/OOS Lite provider will have the option to upgrade from OPR/OOS Lite to a fully enrolled provider..
Note	Upgrading from OOS Lite to fully enrolled will require payment of the \$100 NC Application Fee.

4.3 INDIVIDUAL BASIC INFORMATION PAGE

The MCR is pre-populated with the last information provided.

Individual Basic Information

* indicates a required field

Legend

IDENTIFYING INFORMATION

* Last Name:

* First Name:

Middle Name:

Suffix:

-- Select One --

(Enter your full middle name)

* Date of Birth:

mm/dd/yyyy

* SSN:

* Gender:

-- Select One --

* NPI:

0000000000

* Email:

☐ I attest that I have given my full legal name, and I do not have a middle name.

EMPLOYER IDENTIFICATION NUMBER (EIN)

* Will your income be reported to an EIN?

Yes

No

* EIN:

00-0000000

* DBA Name:

* Years Doing Business Under This Name:

RENDERING/ATTENDING ONLY PROVIDER

* Are you a Rendering/Attending Only provider?

Yes

No

OWNERSHIP INFORMATION

* Business Type:

-- Select One --

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:

* First Name:

Middle Name:

Suffix:

-- Select One --

(Enter your full middle name)

* Contact Email:

* SSN:

* Office Phone #:

(000) 000-0000

ext.

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.

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 »

Exhibit 40. Individual Basic Information Page

PUG_PRV111

FINAL

Page 51 of 102

PUG_PRV111_ProvWebPortApps_V7.9

4.4 HEALTH / BENEFIT PLAN SELECTION PAGE

This page allows you to manage your participation in the NC DHHS health and benefit plans. You can view your status, reinstate participation, add new participation, and terminate participation.

Note: A \$100 NC Application Fee is required for Individual providers when applying for Medicaid. For In-State, Border, OPR Lite, and OOS Full Organizations and Atypical Organizations, a \$100 NC Application Fee is required when applying for Medicaid. For OOS Lite providers, the \$100 NC Application Fee is not required. Note: The \$100 NC Application Fee has been reinstated for all Enrollment and Re-verification applications effective July 1, 2023.

4.4.1 Current Status

Health / Benefit Plan Selection

* indicates a required field

What are the qualifications and requirements for the NC DHHS Health Plans?
See [Provider Permission Matrix](#).

Legend

CURRENT STATUS

1	2	3	4	5
Health Plan	Health Plan Status	Benefit Plan	Benefit Plan Status	Effective Date
TITLE NCXIX	ACTIVE			05/01/2022
TITLE NCXXI	NEW			
MENTAL HEALTH SERVICES	NEW			
		ADULT DISABILITY INTELLECTUAL DEVELOPMENTAL DISABILITY	NEW	
		Adult with Mental Illness	NEW	
		TRANSITIONS TO COMMUNITY LIVING	NEW	
		ADULT MENTAL HEALTH COUNTY FUNDS	NEW	
		ADULT MENTAL HEALTH VETERAN AND FAMILY	NEW	
		Child Mental Health Seriously Emotionally Disturbed with Out-of-Home Placement	NEW	
		CHILD MENTAL HEALTH COUNTY FUNDS	NEW	
		GENERIC ASSESSMENT PAYMENT	NEW	
SUBSTANCE ABUSE SERVICES	NEW			
		Adult Substance Abuse Injecting Drug User	NEW	
		Adult SA COVID Opioid Use Disorder	NEW	
		ADULT SUBSTANCE ABUSE OPIOID USE DISORDER	NEW	
		Adult Substance Abuse Treatment Engagement and Recovery	NEW	
		Adult SA Stimulant Use Disorder	NEW	
		ADULT SUBSTANCE ABUSE COUNTY FUNDS	NEW	
		Adult Substance Abuse Women	NEW	
		Child Substance Abuse Child with Substance Abuse Disorder	NEW	
		CHILD SUBSTANCE ABUSE COUNTY FUNDS	NEW	
DEVELOPMENTALLY DISABLED SERVICES	NEW			
		Adult with Developmental Disability	NEW	
		ADULT DEVELOPMENTAL DISABILITY COUNTY FUNDS	NEW	
		Child Developmental Disability	NEW	
		CHILD DEVELOPMENTAL DISABILITY COUNTY FUNDS	NEW	
PUBLIC HEALTH	NEW			
		AIDS Drug Assistance Program	NEW	
		Early Hearing Detection and Intervention Program	NEW	
		Infant Toddler	NEW	
		Sickle Cell	NEW	
RURAL HEALTH	NEW			
		Community Care of North Carolina -Uninsured Parents	NEW	
		Healthnet	NEW	

TYPE OF UPDATE

* Update Type: Add/Reinstate Health Plan Option(s)

DIVISION OF HEALTH BENEFITS, DIVISION OF PUBLIC HEALTH, OFFICE OF RURAL HEALTH

Please select any coverage types for which you wish to enroll by checking the corresponding box.

If you are a Behavioral Health provider intending to contract with a Local Management Entity-Managed Care Organization (LME-MCO), contact the LME-MCO before completing an application in NCTracks. Enrollment in Medicaid or NC Health Choice does not guarantee a contract with a LME-MCO.

NC Session Law 2022-74 eliminates NC Health Choice and moves beneficiaries to Medicaid. Effective April 1, 2023, Medicaid is the only NC DHHS health plan offered by DHB. As needed, you may enroll in NCHC to cover prior dates of service, but your participation in the NCHC health plan will end effective April 1, 2023.

Division of Health Benefits (DHB)

☐ Medicaid ☒ NCHC (Children)

* NCHC (Children) Begin Date: 02/14/2023

Division of Public Health (DPH)

☐ Infant Toddler ☐ Sickle Cell

☐ Early Hearing Detection Intervention ☐ AIDS Drug Assistance Program

Office of Rural Health (ORH)

☐ Migrant Health

Previous Next

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

Exhibit 41. Health / Benefit Plan Selection Page – Current Status Section

Item	Description
1	<p>Health Plan: Identifies the NC DHHS health plans:</p> <ul style="list-style-type: none"> Title NCXIX – Medicaid Public Health Rural Health <p>Note: Effective April 1, 2023, Medicaid will be the only NC DHHS health plan offered by DHB.</p>

Item	Description
2	<p>Health Plan Status: Provider's current status in the health plan:</p> <ul style="list-style-type: none"> • Active – Provider is currently active. • Terminated – Provider is currently terminated (not active). • New – Provider can add this health plan. <p>If you hover over using your mouse, more information displays.</p>
3	Benefit Plan: If applicable, benefit plans are displayed.
4	<p>Benefit Plan Status: If applicable, the status of your participation in the benefit plans displays:</p> <ul style="list-style-type: none"> • Active – Provider is currently active. • Terminated – Provider is currently terminated (not active).
5	<p>Effective Date: This is the effective date of the provider status. In this example, this provider has been active in Title NCXIX since 3/1/2013 and has been terminated in NCXXI since 3/13/2013.</p> <p>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. The effective date cannot be more than 90 days in the future.</p> <p>Note: CCNC/CA participation effective date may not be retroactively requested.</p>
Note	If an OOS Lite provider upgrades to a fully enrolled provider, they will then have the option to participate in all health plans.

4.4.2 Type of Update

In the **Type of Update** section, you select the type of update that you want to make.

TYPE OF UPDATE ?

1 * Update Type: Remove Health/Benefit Plan(s) [dropdown menu with options: No Updates, Remove Health/Benefit Plan(s), Add/Reinstate Health Plan Option(s)]

* Would you like to remove TITLE NCXXI from your active Health Plans?
☐ Yes ☒ No

* Would you like to remove TITLE NCXXI from your active Health Plans? 2

TITLE NCXXI End-date Info ?

* End Date: mm/dd/yyyy [calendar icon]

* Reason for ending coverage: [dropdown menu]

Comments: [text area]

* Would you like to remove PUBLIC HEALTH from your active Health Plans?
☐ Yes ☒ No

* Would you like to remove one or more benefit plans from your PUBLIC HEALTH Health Plan?
☒ Yes ☐ No

Remove PUBLIC HEALTH Benefit Plans ?

Please enter an end date for plans youd like to remove

PUBLIC HEALTH BENEFIT PLANS		
Benefit Plan	Begin Date	End Date
Infant Toddler	05/01/2007	mm/dd/yyyy [calendar icon]
Sickle Cell	05/01/2007	mm/dd/yyyy [calendar icon]
Early Hearing Detection and Intervention Program	05/01/2007	mm/dd/yyyy [calendar icon]
AIDS Drug Assistance Program	05/01/2007	mm/dd/yyyy [calendar icon]

* Would you like to remove RURAL HEALTH from your active Health Plans?
☐ Yes ☒ No

((Previous Please be sure to complete all required fields with valid content. Next))

Save Draft Delete Draft

Exhibit 42. Health / Benefit Plan Selection Page – Type of Update Section

Step	Action
1	<p>Update Type:</p> <ul style="list-style-type: none"> No Updates: Select if you do not want to make any changes. Note: In MCR applications, the default is set to 'No Updates'. Remove Health/Benefit Plan(s): Select if you want to terminate participation in one or more health/benefit plans. Note: If you select this option, the section will expand with questions that you are required to answer. Add/Reinstate Health Plan Option(s): Select if you want to add or reinstate terminated health/benefit plans. Note: If you select this option, the section will expand for you to select the health plan options to add or reinstate from DHB, DPH, or ORH.
2	<p>For removing Health/Benefit Plans, the questions: 'Would you like to remove [title of Health/Benefit Plan] from your active Health Plans?' display. Select Yes or No for each question.</p> <ul style="list-style-type: none"> If you select Yes, you must enter the End Date, select the Reason for ending coverage, and enter Comments if applicable. If you select No, the section will expand, displaying the question: 'Would you like to remove one or more benefit plans from your PUBLIC HEALTH Health Plan?'. If you select Yes, a list of Public Health Benefit Plans displays for you to select the end date for

Step	Action
	<p>the desired plan(s).</p> <ul style="list-style-type: none"> Selecting No to all other questions will not prompt any other questions. You may continue to the next page.

4.5 ADDRESSES PAGE

All addresses on file for a provider display on the **Addresses** page. You can edit, end-date, or add new addresses.

Note: Providers must have active participation in Medicare or their home state Medicaid Program for every OOS and border service location entered on the application. If the provider is an OOS or border provider with an OOS or border service location, Credentialing staff will confirm the provider is active with Medicare for each location listed. If not active with Medicare, Credentialing staff will contact the provider's home state Medicaid Program.

4.5.1 Reinstate an End-Dated Address

If one of your addresses has been end-dated, it is not necessary to add the address; you can reinstate the address.

The screenshot shows the 'Service Locations' page. Under the 'SERVICE LOCATION 2' tab, the 'Address' section is expanded. It contains fields for 'Address Line 1', 'Address Line 2', 'City', 'State', 'ZIP Code', 'County', 'Begin Date', and 'End Date'. The 'End Date' field is highlighted with a red circle and the number 2. The 'Edit' button at the bottom right is highlighted with a red circle and the number 3. A red circle with the number 1 is also present near the 'Address' section header.

Exhibit 43. Addresses Page – Reinstate an End-Dated Address #1

Step	Action
1	Expand the Service Location to display the Address fields.
2	End Date: Displays end date on file for this address.
3	Select the Edit button.
Note	If an OPR Lite provider upgrades to a fully enrolled provider, they will then have the ability to add service locations.

Service Locations

SERVICE LOCATION 2

After updating the fields, please click the Save button.

Service Location Name:

* Office Phone #: ext. Office Fax #:

Address

Address Line 1:

Address Line 2:

* City:

State:

* ZIP Code: County:

Begin Date: End Date:

☒ Re-instate **4**

* New Begin Date: **5**

Servicing Counties

Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees.

County	County	County	County
<input type="checkbox"/> ALAMANCE	<input type="checkbox"/> ALEXANDER	<input type="checkbox"/> ALLEGHANY	<input type="checkbox"/> ANSON
<input type="checkbox"/> ASHE	<input type="checkbox"/> AVERY	<input type="checkbox"/> BEAUFORT	<input type="checkbox"/> BERTIE
<input type="checkbox"/> BLADEN	<input type="checkbox"/> BRUNSWICK	<input type="checkbox"/> BUNCOMBE	<input type="checkbox"/> BURKE
<input type="checkbox"/> CABARRUS	<input type="checkbox"/> CALDWELL	<input type="checkbox"/> CAMDEN	<input type="checkbox"/> CARTERET
<input type="checkbox"/> CASWELL	<input type="checkbox"/> CATAWBA	<input type="checkbox"/> CHATHAM	<input type="checkbox"/> CHEROKEE
<input type="checkbox"/> CHOWAN	<input type="checkbox"/> CLAY	<input type="checkbox"/> CLEVELAND	<input type="checkbox"/> COLUMBUS
<input type="checkbox"/> CRAVEN	<input type="checkbox"/> CUMBERLAND	<input type="checkbox"/> CURRITUCK	<input type="checkbox"/> DARE

6

Exhibit 44. Addresses Page – Reinstate an End-Dated Address #2

Step	Action
4	Begin Date: Select Re-instate checkbox.
5	New Begin Date: Enter New Begin Date .
6	Select the Save button.

4.5.2 End-Date an Active Address

If one of your addresses will be closed, you can end-date the address.

After updating the fields, please click the Save button.

Service Location Name: [Text Field]

* Office Phone #: [Text Field] ext. [Text Field] Office Fax #: [(000) 000-0000]

Address

Address Line 1: [Text Field]

Address Line 2: [Text Field]

* City: [Text Field]

State: [Dropdown Menu]

* ZIP Code: [Text Field]

County: Durham

Begin Date: [Text Field]

* End Date: [Text Field]

1 ☒ End Date It

2

Servicing Counties

Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees.

County	County	County	County
<input type="checkbox"/> ALAMANCE	<input type="checkbox"/> ALEXANDER	<input type="checkbox"/> ALLEGHANY	<input type="checkbox"/> ANSON
<input type="checkbox"/> ASHE	<input type="checkbox"/> AVERY	<input type="checkbox"/> BEAUFORT	<input type="checkbox"/> BERTIE
<input type="checkbox"/> BLADEN	<input type="checkbox"/> BRUNSWICK	<input type="checkbox"/> BUNCOMBE	<input type="checkbox"/> BURKE
<input type="checkbox"/> CABARRUS	<input type="checkbox"/> CALDWELL	<input type="checkbox"/> CAMDEN	<input type="checkbox"/> CARTERET
<input type="checkbox"/> CASWELL	<input type="checkbox"/> CATAWBA	<input type="checkbox"/> CHATHAM	<input type="checkbox"/> CHEROKEE
<input type="checkbox"/> CHOWAN	<input type="checkbox"/> CLAY	<input type="checkbox"/> CLEVELAND	<input type="checkbox"/> COLUMBUS
<input type="checkbox"/> CRAVEN	<input type="checkbox"/> CUMBERLAND	<input type="checkbox"/> CURRITUCK	<input type="checkbox"/> DARE

3

Exhibit 45. Addresses Page – End-Date an Active Address

Step	Action
1	Select the End Date It checkbox.
2	End Date: Enter the End Date .
3	Select the Save button.

4.6 TAXONOMY CLASSIFICATION PAGE

The **Type, Classification and Area of Specialization** section of the **Taxonomy Classification** page allows you to edit current taxonomies.

Note: If an existing provider adds a new location with a taxonomy indicated on the Provider Permission Matrix, the **Federal Requirements** page will display (see [Section 3.29](#)). The Federal Site Visit and Federal Fee will be required.

Taxonomy Classification

* Indicates a required field

Legend

SERVICE LOCATIONS

Select	Location	Form Status
		Complete
		Complete

To complete information for each service location, select the appropriate location then click the "Edit Location" button.

Edit Location

Taxonomy Classification

SCHOOL BASED HEALTH CENTER

* Is your organization a School Based Health Center (SBHC)?

☐ Yes ☒ No

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

1 TYPE, CLASSIFICATION AND AREA OF SPECIALIZATION

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

- * TAXONOMY CLASSIFICATION - 193200000X - MULTI-SPECIALTY --- END DATED
- * TAXONOMY CLASSIFICATION - 251B00000X - CASE MANAGEMENT
- TAXONOMY CLASSIFICATION - 282N00000X - GENERAL ACUTE CARE HOSPITAL --- END DATED

Provider Type: HOSPITALS
Classification: General Acute Care Hospital
Area of Specialization: None

Begin Date: 03/14/2013 End Date: 03/15/2013 Status: ENDDATED
Reason Code: Voluntary Termination. No Ion

2 Edit

Exhibit 46. Taxonomy Classification Page

Step	Action
1	Expand a taxonomy listed in the Type, Classification and Area of Specialization section. Note: The information for the taxonomy will display as read-only.
2	Select the Edit button to enable the system to edit the taxonomy information. Notice certain editable information: <ul style="list-style-type: none"> Begin Date: Begin date of the current status. Status: Current status of the provider for this taxonomy: <ul style="list-style-type: none"> Active – Provider is currently active. Terminated – Provider is currently terminated (not active). Suspended – Provider is currently suspended. Select the Save button once you have completed the edits.

4.6.1 End-Date a Taxonomy

If you want to terminate participation in a taxonomy, you can end-date the taxonomy.

Note: You must have at least one active taxonomy in order to remain an active provider.

TAXONOMY CLASSIFICATION - 282N00000X - GENERAL ACUTE CARE HOSPITAL

After updating the fields, please click the **Save** button.

Provider Type: **HOSPITALS**
Classification: **General Acute Care Hospital**
Area of Specialization: **None**

Begin Date: **03/14/2013** Status: **ACTIVE**

1 ☒ **End Date It**
2 * End Date:
3 * Reason Code: **-- Select One --**

4 **Save**

+ TAXONOMY CLASSIFICATION - 3536C0005X - COMMUNITY/RETAIL PHARMACY

Once all taxonomies have been added, click the "**Save Location**" button to save.

5 **Save Location**

Next >>

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

Save Draft **Cancel Enrollment**

Exhibit 47. Taxonomy Classification Page – End-Date a Taxonomy

Step	Action
1	Select the End Date It checkbox.
2	End Date: Enter the End Date .
3	Select the Reason Code : Reason for terminating participation.
4	Select the Save button.
5	Select the Next button to continue.

4.6.2 Reinstate a Taxonomy

If one of your taxonomy codes has been end-dated, it is not necessary to add the taxonomy; you can reinstate the taxonomy.

TAXONOMY CLASSIFICATION - 251B00000X - CASE MANAGEMENT

After updating the fields, please click the **Save** button.

Provider Type: **AGENCIES**
Classification: **Case Management**
Area of Specialization: **None**

Begin Date: **03/13/2013** Status: **ENDDATED**

1 ☒ **Re-instate**
2 * New Begin Date:
3 **Save**

Exhibit 48. Taxonomy Classification Page – Reinstate a Taxonomy

Step	Action
1	Select the Re-instate checkbox.
2	New Begin Date: Enter the New Begin Date .
3	Select the Save button.

4.7 AFFILIATED PROVIDER INFORMATION PAGE

Individual providers can add, update, or end-date affiliations using an MCR. When adding a new affiliation, you can affiliate to an Organization whose overall status is active, suspended, or terminated as well as affiliate to an active or end-dated service location. You can also edit the begin date of the new affiliation (not to exceed the effective begin date of the enrolled provider or the Organization). When editing an existing affiliation, you can edit requested begin dates as well as end-date the affiliation.

Note: This section does not apply to OOS Lite or OPR Lite providers.

4.7.1 Add Affiliations

From the **Affiliated Provider Information** page, you can edit the begin date of an affiliation. Affiliations can also be terminated if necessary by editing the end date.

The screenshot shows the 'Affiliated Provider Information' page. The 'Add Affiliated Provider' section is highlighted. It includes a text box for 'Enter organization's NPI and click 'Lookup NPI''. Below this are fields for 'NPI' (with a red asterisk indicating it's required), 'Organization Name', and 'Enrollment Effective Date' (set to 08/10/2015). A section titled 'Please select locations of affiliated provider.' contains a table with columns: 'Location', 'Begin Date', 'End Date', and 'Do you wish to participate in CCNC/CA under this group?'. The table has one row with a selected location, a begin date of 08/10/2015, an end date of 12/31/9999, and 'N/A' for the group participation. An 'Add' button is at the bottom right of the table.

Exhibit 49. Affiliated Provider Information Page – Add an Affiliation

Step	Action
1	Enter the NPI of the Organization or Atypical provider to which you want to affiliate. Select the Lookup NPI button.
2	Select the Location for the affiliation.
3	Enter the effective date of the affiliation.
4	Select the Add button to save the affiliation.
Note	If a claim is pended due to Affiliation Claim Edit 07025 (Rendering Provider Not Affiliated with Billing Provider) and an affiliation is not added or updated within 60 days, the claim will deny.

4.7.2 Edit an Existing Affiliation

Users can edit the Begin Date of an existing affiliation. Users can edit the End Date if the affiliation needs to be terminated. The following exhibit shows how an existing active affiliation will display when the **Edit** button is selected.

Affiliated Provider Information

* indicates a required field

Legend

AFFILIATED PROVIDERS

The affiliation allows this organization to bill and receive payment on your behalf.

AFFILIATED PROVIDER ()

After updating the fields, please click the Save button.

NPI:

Organization Name:

Enrollment Effective Date: 01/01/2014

* Please select locations of affiliated provider.

Location	Begin Date	End Date	New Begin Date	New End Date	Do you wish to participate in CCNC/CA under this group?
1	03/28/2014	12/31/9999			N/A

2 Save

Exhibit 50. Affiliated Provider Information Page – Edit an Affiliation

Step	Action
1	Enter the New Begin Date and/or the New End Date if the affiliation needs to be terminated.
2	Select the Save button.
Note	If a claim is pended due to Affiliation Claim Edit 07025 (Rendering Provider Not Affiliated with Billing Provider) and an affiliation is not added or updated within 60 days, the claim will deny.

4.7.3 Reinstate an Affiliation

When an affiliation is end-dated, the provider can reinstate the affiliation by entering a New Begin Date. The following exhibit shows how an existing end-dated affiliation will display when the affiliation segment is expanded and the **Edit** button is selected.

Affiliated Provider Information

* indicates a required field

Legend

Affiliated Providers

The affiliation allows this organization to bill and receive payment on your behalf.

- + Affiliated Provider ()
- + Affiliated Provider ()
- + Affiliated Provider ()
- + Affiliated Provider ()
- + Affiliated Provider ()
- Affiliated Provider ()

After updating the fields, please click the **Save** button.

NPI:

Organization Name:

Enrollment Effective Date: 08/01/2005

* Please select locations of affiliated provider.

	Location	Begin Date	End Date	New Begin Date	New End Date	Do you wish to participate in CCNC/CA under this group?
<input checked="" type="checkbox"/>		08/01/2005	06/30/2012	mm/dd/yyyy	12/31/9999	N/A

Save

Exhibit 51. Affiliated Provider Information Page – Reinstate an Affiliation

Step	Action
1	Enter the affiliation New Begin Date .
2	Select the Save button.
Note	If a claim is pended due to Affiliation Claim Edit 07025 (Rendering Provider Not Affiliated with Billing Provider) and an affiliation is not added or updated within 60 days, the claim will deny.

4.8 COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS (CCNC/CA) PAGE

If you are active in CCNC/CA, the **Community Care of North Carolina/Carolina ACCESS (CCNC/CA)** page displays your CCNC/CA Begin Date and CCNC/CA Contact Person details. You can edit your CCNC/CA Contact Person Information or terminate your participation as a CCNC/CA PCP.

Note: PCPs cannot terminate without giving a 30-day notice; therefore, the CCNC/CA End Date must be the last day of a month and at least 30 days in the future.


Note: If you are eligible to be a CCNC/CA PCP and you are not currently active in CCNC/CA, this page displays exactly as it does in [Initial Enrollment applications](#).

Community Care of North Carolina/Carolina ACCESS

* Indicates a required field

Legend

SERVICE LOCATIONS

Select	Location	Form Status
	(Primary Location)	Complete

To complete information for each service location, select the appropriate location then click the "Edit Location" button.

Edit Location

Community Care of North Carolina/Carolina ACCESS

To complete information for this location, fill out this form section then click 'Save Location' in lower right.

COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS

As a Medicaid Provider, you are eligible to enroll as a CCNC/CA Provider if one of your taxonomy classifications is on the [CCNC/CA Eligible Provider Types List](#).

CCNC/CA CONTACT PERSON

1 * Last Name: * First Name:
 Middle Name: Suffix: -- Select One --
 * Office Phone #: ext. Other Phone #: ext.
 Office Fax #: * Contact Email:

2 CCNC/CA Begin Date: 3 ☐ End Date It:

Save Location

4

Please be sure to complete all required fields with valid entries

Next >

Exhibit 52. CCNC/CA Page

Step	Action
1	CCNC/CA Contact Person: Contact information on file. You can edit any of these fields.
2	CCNC/CA Begin Date: Your begin date as a CCNC/CA PCP.
3	Select the End Date It checkbox if you want to terminate your CCNC/CA participation.
4	Select the Next button to continue.

5.0 Re-enrollment Application

5.1 STATUS AND MANAGEMENT PAGE

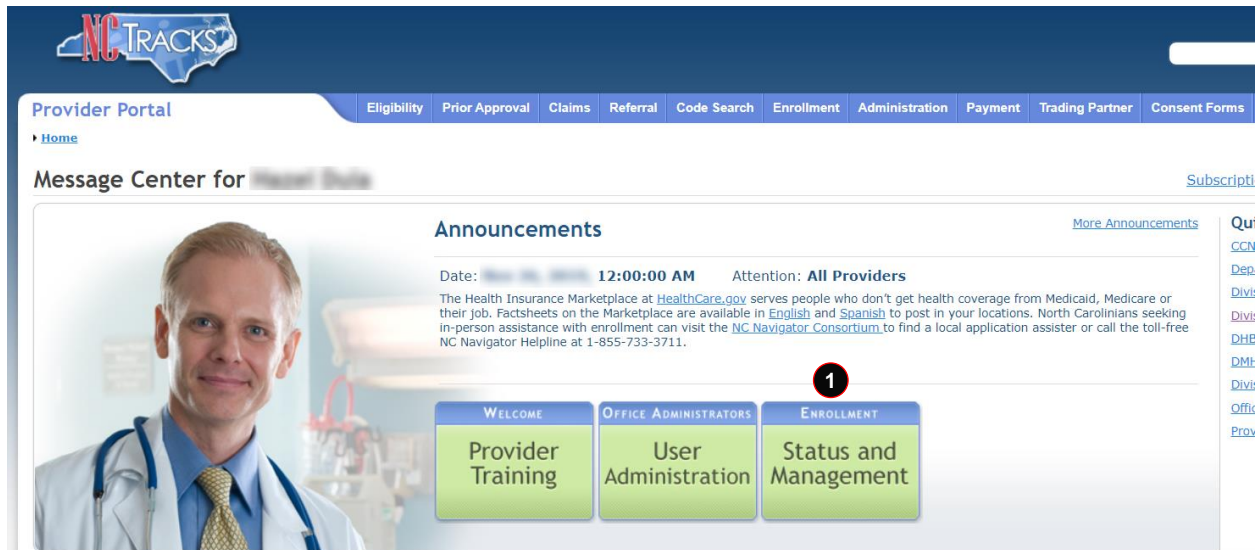


Exhibit 53. Provider Portal Home Page

Step	Action
1	From the secure Provider Portal Home page, select the Status and Management button. The Status and Management page displays. To begin a Re-enrollment application, scroll down to the Re-enroll section.

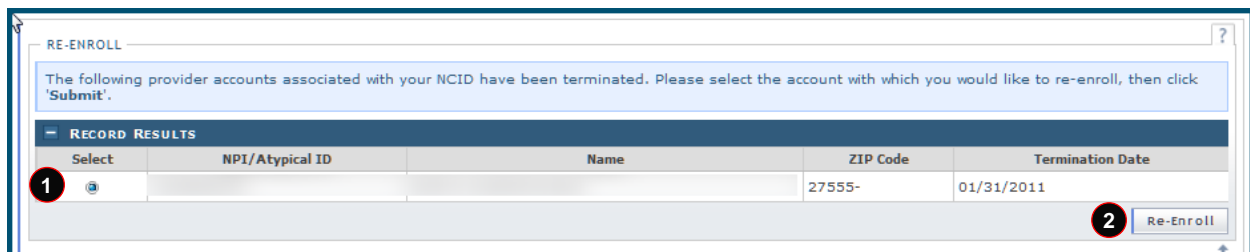


Exhibit 54. Status and Management Page – Re-enroll Section

Step	Action
1	Select the radio button next to the record for which you want to begin a Re-enrollment application.
2	Select the Re-Enroll button.

You will be taken to the **Individual Basic Information** or **Organization Basic Information** page to begin the application. The pages look similar to the pages for [Initial Enrollment](#) and [MCR](#) applications. The only difference is that all health plans, taxonomy codes, services, etc. will be end-dated. You will need to reinstate this information as desired.

Note: The \$100 NC Application Fee is never required when submitting a Re-enrollment application.

This Page Intentionally Left Blank

6.0 Re-verification Application

6.1 NOTIFICATION LETTERS

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 re-verification due date. The Re-verification Letter instructs the provider to navigate to the **Status and Management** page and electronically complete and submit the Re-verification application. Reminder letters will be sent at 50, 20, and 5 days prior to the Re-verification due date if the Re-verification application has not been submitted.

If the application is NOT submitted prior to the re-verification due date, the provider's record will be suspended. A Re-verification Suspension Letter will be sent to the provider's Message Center inbox and via US Mail.

The provider's DHB and DPH claims will pend if their record is suspended. Claims will continue to pend until the Re-verification application is submitted.

If the provider has not submitted the Re-verification application during the 50-day suspension period, the provider's DHB, Division of Mental Health (DMH), and DPH health plans will be terminated. A termination letter will be mailed to the provider. An automated process will release the provider's pended claims to continue the adjudication process.

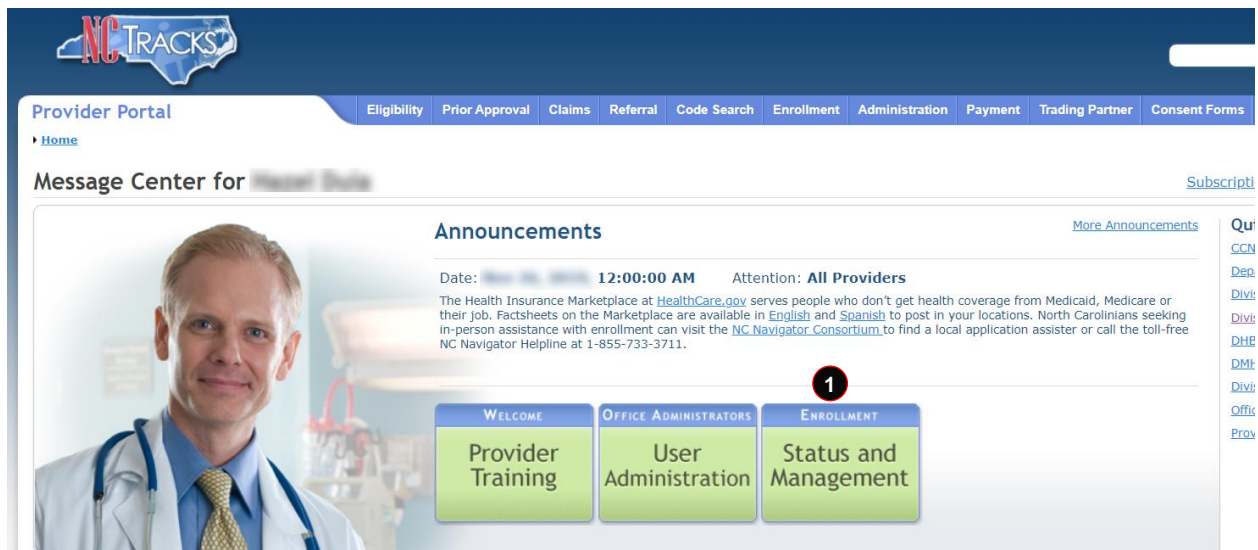


Exhibit 55. Provider Portal Home Page

Step	Action
1	From the secure Provider Portal Home page, select the Status and Management button. The Status and Management page displays. To begin a Re-verification application, scroll down to the Re-verification section.

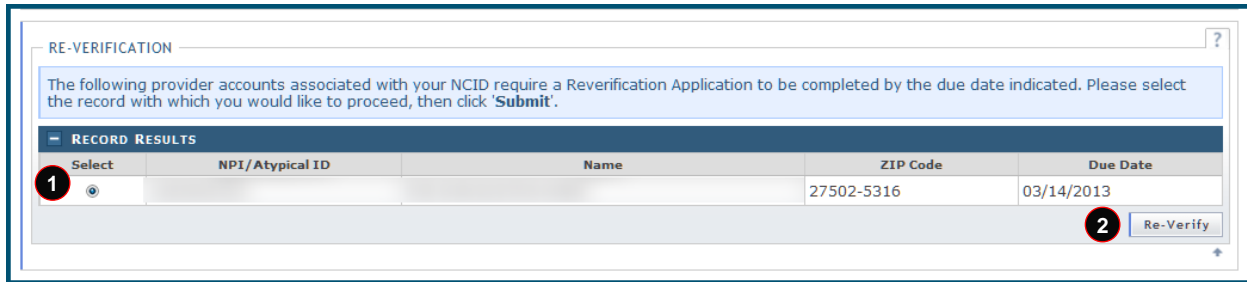


Exhibit 56. Status and Management Page – Re-verification Section

Step	Action
1	Select the radio button next to the record for which you want to begin a Re-verification application.
2	Select the Re-Verify button. The Re-verification Application – Individual Provider or Re-verification Application – Organization page displays.

6.2 RE-VERIFICATION APPLICATION – INDIVIDUAL PROVIDER/ORGANIZATION PAGE

When the provider selects his/her record from the **Re-verification** section on the **Status and Management** page, the Provider Portal will present all of the UI pages as if the provider is completing a full MCR. The provider will be required to review all pages and can make updates as necessary including updating required licensure, certification, and accreditation.

- The provider will be able to upgrade from OPR Lite to full provider.
- The provider will not be able to end-date health plans but will be able to add/reinstate health plans.
- The provider will be required to review and complete the **Provider Supplemental Information** page (individual providers only).

The **Re-verification Application – Individual Provider** or **Re-verification Application – Organization** page displays specific information about you as an Individual or Organization provider. This information must match what is reported on your income tax return.

If the information (Name, DOB, SSN, or EIN) submitted on the application is incorrect and does not match our findings during the background check, CSRA will return the application and send the OA an Application Incomplete letter. After reviewing the incorrect information indicated in the letter, if the provider agrees that the information is incorrect, the OA should navigate to the **Status and Management** page and withdraw the application. The provider may also respond to the Application Incomplete letter advising that the information is incorrect and requesting CSRA to withdraw the application.

Note: CSRA strongly recommends that the provider withdraw the application from the **Status and Management** page.

Applications withdrawn by CSRA or the provider will have a 'Withdrawn' status in the **Submitted Applications** section of the **Status and Management** page. CSRA-withdrawn applications will always be accompanied by a withdrawal letter. Providers do not receive correspondence when the withdrawal is completed in the Provider Portal.

Please note that if your Re-verification application has been withdrawn due to inaccurate data after your Re-verification due date, your health plans will terminate 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 or need further information, please feel free to call the **NCTracks Call center** at **1-800-688-6696** for assistance.

Individual Basic Information

* indicates a required field

Legend

IDENTIFYING INFORMATION

Last Name: MEELHEIM	First Name: HELEN
Middle Name: DIANE	Suffix: -- Select One --
Date of Birth: 03/25/1952	SSN: ***-**-5656
Gender: F	NPI/Atypical Provider ID: 1326185372
* Email: TEST@FAKEEMAIL.	

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):		* First Name: HELEN
* Last Name: MEELHEIM		Suffix: -- Select One --
Middle Name: DIANE	(Enter your full middle name)	
* Contact Email: TEST@FAKEEMAIL.		SSN ***-**-5656
* Office Phone #: (252)-728-5737 ext.		Office Fax #:

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

Next >>

Exhibit 57. Re-verification Application – Individual Provider Page

Re-Verification Application - Organization Basic Information

* Indicates a required field

AA Help

Legend

IDENTIFYING INFORMATION

If you need to update the Organization Name, submit documentation that shows proof of a legal name change to CSRA via fax at 855-710-1965 or by email at NCTracksprovider@nctracks.com.

Organization Name:

EIN:

NPI/Atypical Provider ID:

* Email:

* Month of Fiscal Year End:

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:

REGISTERING WITH NC SECRETARY OF STATE

Are you required by law to register with NC Secretary of State? ☒ Yes

Secretary of State ID #:

OFFICE ADMINISTRATOR (AUTHORIZED INDIVIDUAL)

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

* User ID (NCID):

* Last Name:

Middle Name:

(Enter your full middle name)

* First Name:

Suffix:

* Contact Email:

SSN:

* Office Phone #: ext.

Office Fax #:

* Is this contact person an Owner or Managing Employee?

☐ Owner ☒ Managing Employee

1 Next >

Save Draft

Exhibit 58. Re-verification Application – Organization Page

Step	Action
1	Select the Next button if all information is correct.

6.3 TERMS AND CONDITIONS PAGE

After reading and understanding the Provider Administrative Participation Agreement and the Attestation Agreement, you must select the checkbox next to the Attestation Statement or you will be unable to submit the Re-verification application.

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 incorporated into this Agreement by this reference.

All provider administrative participation agreements with the Department are terminable at will. Nothing in these Regulations creates in the provider a property right or liberty right in continued participation in the Medicaid program.

4. License
The Provider agrees to:

A. Be licensed, certified, registered, accredited and/or endorsed as required by State and/or Federal laws and regulations, and NC DHHS policies and procedures at all times that services are provided.

B. Notify the Department within seven (7) calendar days of learning of any adverse action initiated against the license, certification, registration,

Attestation Statement

* ATTESTATION

☐ I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

« Previous

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

Next »

Exhibit 59. Re-verification Application – Terms and Conditions Page

6.4 OWNERSHIP INFORMATION PAGE

The **Ownership Information** page captures the type(s) of ownership and information about each shareholder/partner with 5% or more ownership as applicable. You can add, edit, or end-date ownership information in the Re-verification application.

Re-Verification Application - Ownership Information

* indicates a required field

AA Help

Legend

1 Do you have one or more Shareholders/Partners with 5% or more ownership? **Yes**

2 ☐ Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity, licensure board and Medicare.

SHAREHOLDER/PARTNER INFORMATION

- INDIVIDUAL -

Last Name : First Name :
Middle Name : Suffix :
Date of Birth: SSN :
Gender :
Email : Phone Number :

☐ 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 :

Relationship to Another Disclosing Person : **None** Percent of Ownership/Control :
Interest :
Begin Date : End Date :

4 Edit

3 **+ INDIVIDUAL -**

Add Shareholder/Partner

Please complete the required information for each shareholder/partner with 5% or more ownership.

5 * This shareholder/partner is:
☐ an individual ☐ a business

6 Next »

Exhibit 60. Ownership Information Page

Step	Action
1	Shareholder/Partner Information: Do you have one or more Shareholders/Partners with 5% or more ownership?: Select Yes or No ; if Yes , the Shareholder/Partner Information section displays.
2	If Yes was selected in Step 1, select the checkbox beside the attestation statement: 'Owners with 5% or more ownership in the enrolling provider entered on this application match what was reported to the provider's state business registration entity, licensure board and Medicare.'
3	Select the plus (+) sign next to the individual or business that needs to be reviewed or edited. The section will expand.
4	Select the Edit button to update owner information or end date if the individual or business is no longer an owner of the organization.
5	Add Shareholder/Partner: Select either an individual or a business .
6	When changes are completed, select the Next button.

6.5 AGENTS AND MANAGING EMPLOYEES PAGE

The **Agents and Managing Employees** page allows the provider to maintain managing relationships. You can add, edit, or end-date managing relationships in the Re-verification application. An MCR is not required if the record has missing or invalid managing employee information.

Agents and Managing Employees AA Help Legend

* Indicates a required field

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.

1 Does the applicant have any agent(s) and/or managing employee(s)? **Yes**

Managing Relationships

Please add all managing relationships below.

2 **+ 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:

3 **Verify Address**
4 **Add Clear**

Exhibit 61. Agents and Managing Employees Page

Step	Action
1	Relationship Disclosure: Does the applicant have any agent(s) or managing employee(s)? Select Yes or No ; if Yes , the Managing Relationships section displays.
2	Expand the managing relationship section that needs to be updated and then select the Edit button.
3	Add or update required information. Select the Verify Address button and then the Add button.
4	Select the Next button.

6.6 ACCREDITATION PAGE

The **Accreditation** page allows the user to view or add an accreditation. The Accreditation Type for required accreditations may be populated as read-only. If the Accreditation Type has not

been populated, select the Accreditation Type from the drop-down menu. Enter the remaining required fields.

Note: The **Accreditation** page displays for Individual providers only.

Re-Verification Application - Accreditation

■ indicates a required field

Legend

ACCREDITATIONS

Add Accreditation

Select an accreditation type from the drop down list and provide the accreditation number.

Accreditation Type: -- Select One --

Accreditation #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

Add Clear

CERTIFICATIONS

+ CERTIFICATION - CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

+ CERTIFICATION - DRUG ENFORCEMENT AGENCY (DEA)

Add Certification

In addition to certifications required for a taxonomy code, enter all additional board certifications.

Select a certification type from the drop down list and provide the certifying entity and certification number.

1 Certification Type: -- Select One --

Certifying Entity: -- Select One --

State: NORTH CAROLINA

Certification #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

2 Add Clear

LICENSES

Taxonomy 207Q00000X - Family Medicine requires the following License Type:

DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO) OR MD FACULTY LIMITED BY STATE MEDICAL BOARD

+ LICENSE - DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO) OR MD FACULTY LIMITED BY STATE MEDICAL BOARD

License Agency: STATE MEDICAL BOARD

License Type: DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO) OR MD FACULTY LIMITED

State: NORTH CAROLINA

License #:

Effective Date: 07/19/1997

Expiration Date: 06/30/2022

Edit

Add License

Select a license type from the drop down list and provide the license number.

License Agency: -- Select One --

License Type: -- Select One --

State: NORTH CAROLINA

License #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

Add Clear

Previous

3 Next

Save Draft Delete Draft

Exhibit 62. Re-verification Application – Accreditation Page

Step	Action
1	Review, edit, and/or enter your board certifications information such as Drug Enforcement Agency (DEA) certifications. <ul style="list-style-type: none">• Certification Type• Certifying Entity• State – Select the state in which you are certified from the drop-down menu.• Certification #• Effective Date• Expiration Date
2	Select the Add button.
3	Select the Next button.

6.7 PROVIDER SUPPLEMENTAL INFORMATION PAGE

The **Provider Supplemental Information** page captures the provider's work history, education, and current malpractice insurance information.

Note: The **Provider Supplemental Information** page displays for Individual providers only.

Re-Verification Application - Provider Supplemental Information

* indicates a required field

Legend

1 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

2 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

3 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

Exhibit 63. Provider Supplemental Information Page

Step	Action
1	<p>In the Work History section of the Provider Supplemental Information page, enter your work history as a health professional:</p> <ul style="list-style-type: none"> Company Name – Employer name Job Title – Position/job title Start Date – Start date of the job title at this company End Date – End date of the job. If you still hold this job title at this company, enter 12/31/9999. <p>Note: For Work Gap: If uploading a work gap history explanation, ensure the letter is signed by the provider and dated.</p>
2	<p>In the Education section, enter your Education information:</p> <ul style="list-style-type: none"> School Name – School or institution name Degree – Highest degree Start Date – Date started at the school or institution Graduation Date – Date graduated from the school with this degree

Step	Action
3	In the Current Malpractice Insurance Coverage section, enter/select the following: <ul style="list-style-type: none"> Do you have malpractice insurance or are you covered under a federal tort? – Select Yes if you have malpractice insurance or are covered under a federal tort Malpractice Type – Select the type of malpractice coverage Insurance Agency Name – Enter the name of the malpractice insurance agency Amount – Enter the amount of malpractice coverage Effective Date – Effective date of the coverage Expiration Date – Expiration date of the coverage
4	Select the Next button.

6.8 FEDERAL REQUIREMENTS PAGE

Providers with taxonomies that are categorized as moderate or high risk are required to meet additional federal requirements.

If the provider has not met these requirements, the **Federal Requirements** page will populate in the Re-verification application. If a new service location is added or a terminated service location is reinstated AND one or more of the taxonomy codes requires the Federal Fee or Site Visit, the Federal Requirements Page will display.

Federal Requirements AA Help

* indicates a required field Legend

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.

* Have you completed the Federal site visit for this site to NC Medicaid, another state or Medicare? 1

2 * Other State: --

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, 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? 3

4 * Other State: --

5

((Previous Please be sure to complete all required fields with valid content. Next))

Save Draft Delete Draft

Exhibit 64. Federal Requirements Page

Step	Action
1	<p>Answer the question: ‘Have you completed the Federal site visit for this site to NC Medicaid, another state or Medicare?’.</p> <ul style="list-style-type: none"> Select NO if you have not completed a Federal Site Visit for this location with either another state or Medicare. Select MEDICARE if completed with Medicare. Select OTHER STATE if completed for another state Medicaid program. <p>Note: If you select NO, Public Consulting Group (PCG) will contact you after the application has been submitted to set up the site visit.</p> <ul style="list-style-type: none"> If you select MEDICARE, CSRA will confirm the site visit completion with Medicare. If you select OTHER STATE, you are required to upload proof of completion as part of the application submission.
2	Other State: If applicable, select the state.
3	<p>Answer the question: ‘Have you paid the Federal Fee for this site to NC Medicaid, another state or Medicare?’.</p> <ul style="list-style-type: none"> Select NO if you have not paid a Federal Fee for this location with either another state or Medicare. Select MEDICARE if paid to Medicare. Select OTHER STATE if completed for another state Medicaid program. <p>Note: If you select NO, upon submission of this application, you will be directed to PayPoint to pay the fee.</p> <ul style="list-style-type: none"> If you select MEDICARE, CSRA will confirm the payment was made with Medicare. If you select OTHER STATE, you are required to upload proof of payment as part of the application submission. <p>Note: When a taxonomy requiring a site visit is added or reinstated to a new, reinstated, or existing location, NCTracks will present the Federal Requirements/Site Visit Completed question only if the provider has not completed a site visit within the past 5 years. Providers will not be required to complete a site visit if a site visit has been completed for the service location within the past 5 years.</p>
4	Other State: If applicable, select the state.
5	Select the Next button to continue.

6.9 EXCLUSION SANCTION INFORMATION PAGE

Welcome, (Log out)
NCTracks Help

Eligibility
Prior Approval
Claims
Referral
Code Search
Enrollment
Administration
Trading Partner
Payment
Consent Forms
Training

Provider Enrollment Ap...

Exclusion Sanction Information
Legend

* indicates a required field

EXCLUSION SANCTION INFORMATION

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

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

For each exclusion sanction 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 in addition to a written explanation of the supporting documentation.

1. A thorough written explanation signed by the subject of the offense if an individual or by the provider's Office Administrator if the subject of the offense is an organization of the occurrence and dated within 6 months of the application date, by the provider's Office Administrator, an owner or managing employee of the occurrence including references to the infraction/conviction date(s) entered and the resolution.
2. All supporting documentation (See Job Aid/FAQ) that relates to the incident.

Failure to submit all of the request information may result in the application being deemed incomplete.

Exclusion Sanction Supporting Documentation [Job Aid/FAQ](#)

1

- * 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
- * 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 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
- * L. Has the enrolling provider had any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from coverage?
☐ Yes ☐ No
- * M. Has the enrolling provider ever practiced without liability coverage?
☐ Yes ☐ No
- * N. Does the enrolling provider have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position?
☐ Yes ☐ No
- * O. Has the enrolling providers hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending?
☐ Yes ☐ No
- * P. Has the enrolling provider had a professional liability claim assessed against them in the past five years or are there any professional liability cases pending against them?
☐ Yes ☐ No

((Previous
Please be sure to complete all required fields with valid content.
Next))

Exhibit 65. Re-verification Application – Exclusion Sanction Information Page

Step	Action
1	<p>Select Yes or No for each Exclusion Sanction question. When Yes is selected for a question, the Infraction/Conviction Dates section displays.</p> <p>For each question answered Yes, you must attach or submit a complete copy of the applicable criminal complaint or disciplinary action, Consent Order, documentation regarding recoupment/repayment settlement action, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application. If uploading an explanation for an affirmative exclusion sanction response, ensure the letter is signed by the provider, person with infraction, or Office Administrator and that the letter is dated. The letter must be dated within the past six months of the date of this application.</p> <p>Disclosure of adverse legal actions may not preclude participation with the NC Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the NC Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).</p> <p>Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p> <p>New questions have been added, so be sure to read each question carefully.</p>

6.10 REVIEW APPLICATION PAGE


Selecting the **Review Application** button displays a window that will allow you to open a PDF file of your application, which you can print and review for accuracy before submitting.

Review Application

A⁻ A⁺[Help](#)

ELECTRONIC SIGNATURE - EMAIL CONFIRMATION

- Please confirm that the email address below is correct. If you don't already have one, an **Electronic Signature PIN** will be sent to this address upon submitting the next page. You will need access to this email address to retrieve/reset your PIN and complete this Online Application.
- If the email below is incorrect, you may now navigate back to the [Basic Information page](#) to update it. (Remember to click 'Next' on the [Basic Information page](#) to store your change.)

Contact Email: 

REVIEW APPLICATION

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

1

Review Application 

« Previous

2

Next »

Application Last Updated: 2009-11-22

Cancel Enrollment


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

Exhibit 66. Review Application Page

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

6.11 SIGN AND SUBMIT ELECTRONIC APPLICATION PAGE

Re-Verification Application - 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 information.

ELECTRONIC SIGNATURE CONFIRMATION

Attestation: I have read and agreed to the terms and conditions of participation. By submitting this form, I confirm the information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this electronic document is submitted. I do hereby attest that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

1 * Login ID (NCID): [Forgot Login ID](#)

2 * Password: [Forgot Password](#)

- If this is your first Provider Enrollment submission, your Electronic Signature PIN has now been sent to . Please retrieve it now to complete submission. If the email is incorrect, you may now navigate back to the Basic Information page to update it. (Remember to click Next on the Basic Information page 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 by entering your Login ID (NCID) and Password and clicking the 'Forgot PIN' link. The PIN will be sent to your email address.

Please contact the CSRA Call center at **800-688-6696** if you have any trouble with your Electronic Signature PIN Number.

3 * PIN: [Forgot PIN](#) 4

Please review the documents you are going to electronically sign.

- [Agreement and Attestations](#)

REQUIRED ATTACHMENTS

None

ONLINE APPLICATION SUBMISSION

You may now submit your Online Application by clicking '**Submit Now**' below. After submitting you will have the option to print a copy of the completed application for your records.

You will also receive instructions to finalize the application process on the next page.

5

Exhibit 67. Sign and Submit Electronic Application Page

Step	Action
1	Login ID: Enter Login ID (NCID) .
2	Password: Enter Password .
3	PIN: Enter PIN .
4	Select the Forgot PIN link if you need to have your PIN reset.
5	Select the Submit button to submit the Re-verification application.

6.12 FINAL STEPS PAGE

Final Steps

* indicates a required field

 |  | [Help](#)

Legend

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.

1

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

2

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.

3

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.

4

Upload Documents

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


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

Exhibit 68. Final Steps Page

Step	Action
1	Application Fee Required: A \$100 NC Application Fee is required from Individual providers, Organizations, and Atypical Organizations if active in Medicaid.
2	If fingerprinting is required, the provider will be notified in the Fingerprinting Required section. The Fingerprint Release of Information form and instructions will be e-mailed to the provider and sent to the Message Center inbox.
3	Required attachments for the application, if any, will be listed in the Required Attachments section.
4	Upload electronic attachments by selecting the Upload Documents button.

The reviewer will confirm that the provider is active in Medicare or their home state Medicaid program for all OOS /border addresses. If not, the location will be denied or terminated; and if the location is the only active location on the record, the entire provider record will terminate.

During the re-verification process, a thorough examination of the provider's qualifications will be performed. The provider's file will be reviewed, and criminal background checks will be performed on all owners and managing relationships associated with the provider record.

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

Re-verification applications abandoned or withdrawn after the suspension date will result in the termination of the provider's Medicaid, DPH, and ORH health plans. If these are the only active health plans on the provider record, a [Re-enrollment application](#) will be required.

The OA/ES user will have access to the notification letters via the Message Center inbox as well as a hyperlink on the **Status and Management** page.

7.0 Maintain Eligibility Application

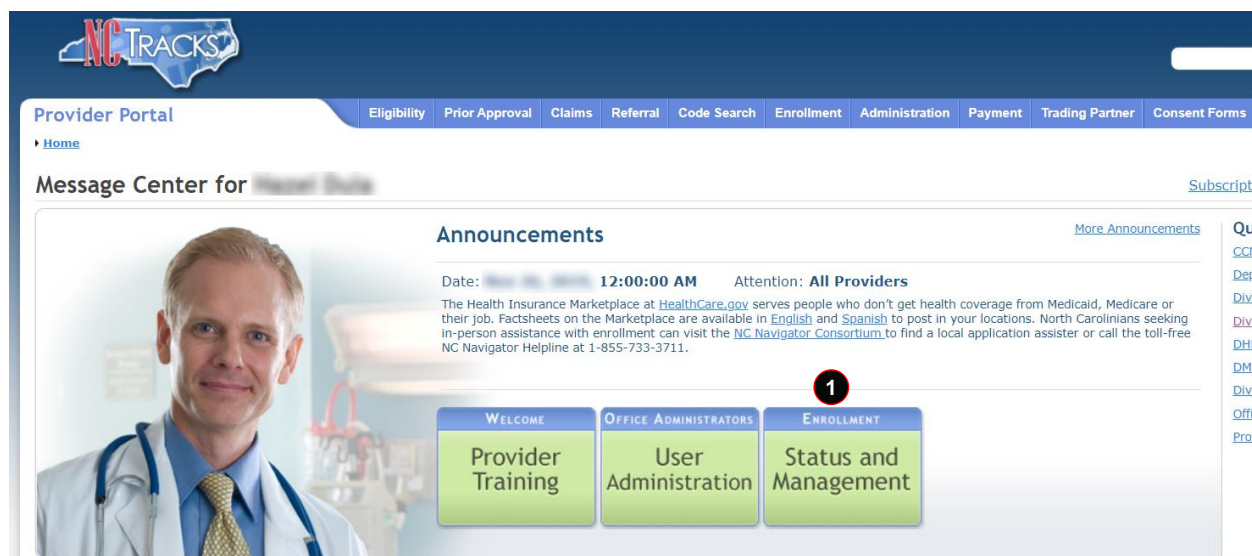


Exhibit 69. Provider Portal Home Page

Step	Action
1	From the secure Provider Portal Home page, select the Status and Management button. The Status and Management page displays. To begin a Maintain Eligibility application, scroll down to the Maintain Eligibility section.

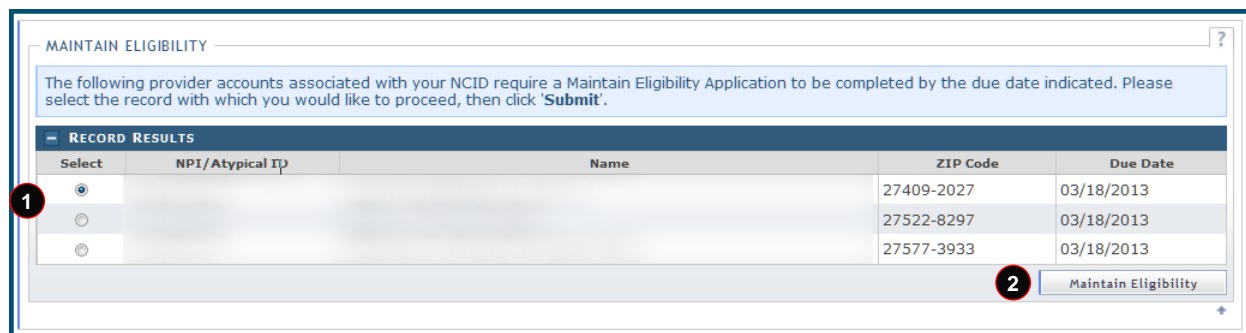


Exhibit 70. Status and Management Page – Maintain Eligibility Section

Step	Action
1	Select the radio button next to the record for which you want to begin a Maintain Eligibility application.
2	Select the Maintain Eligibility button.

The pages look exactly like the Re-verification application pages. See the exhibits in [Section 6.0](#).

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8.0 Fingerprinting Required Application

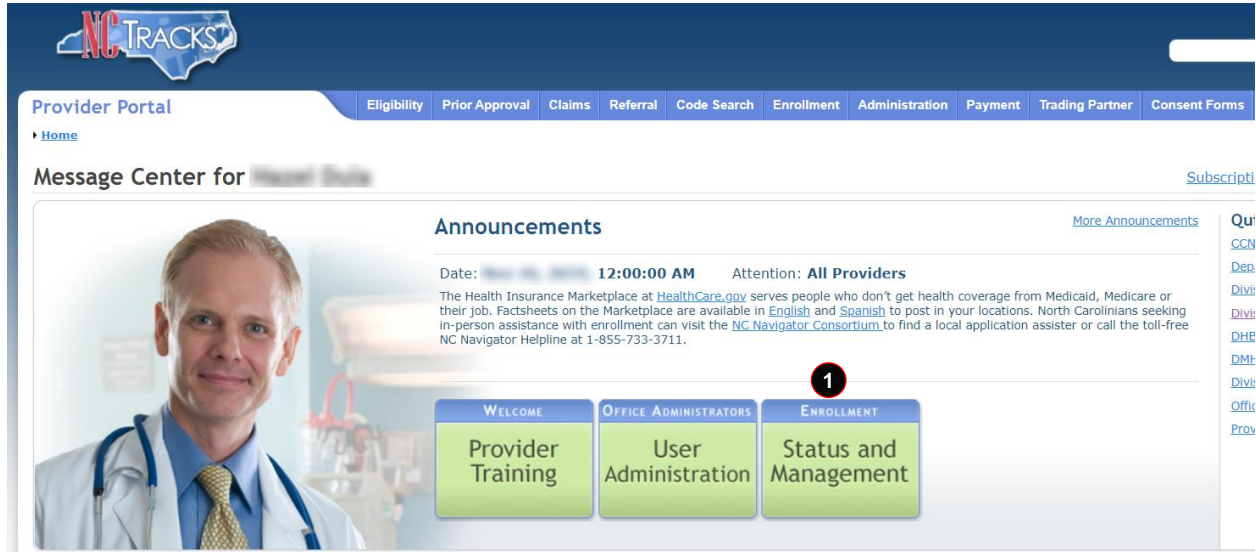


Exhibit 71. Provider Portal Home Page

Step	Action
1	From the secure Provider Portal Home page, select the Status and Management button. The Status and Management page displays. To begin a Fingerprinting Required application, scroll down to the Fingerprinting Required section.

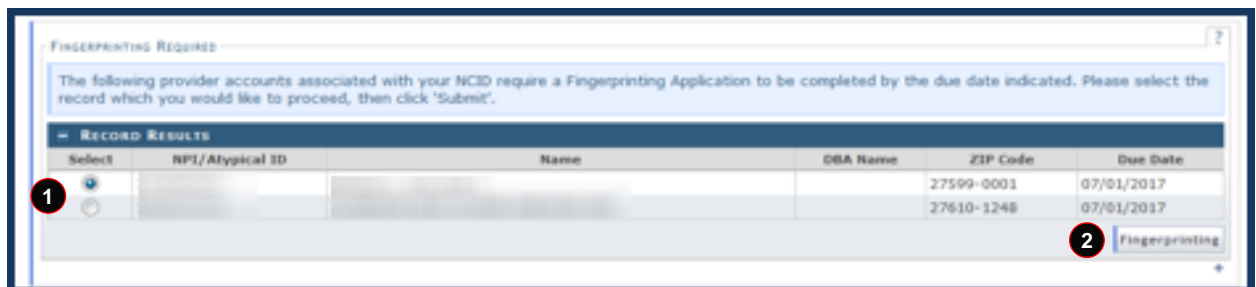
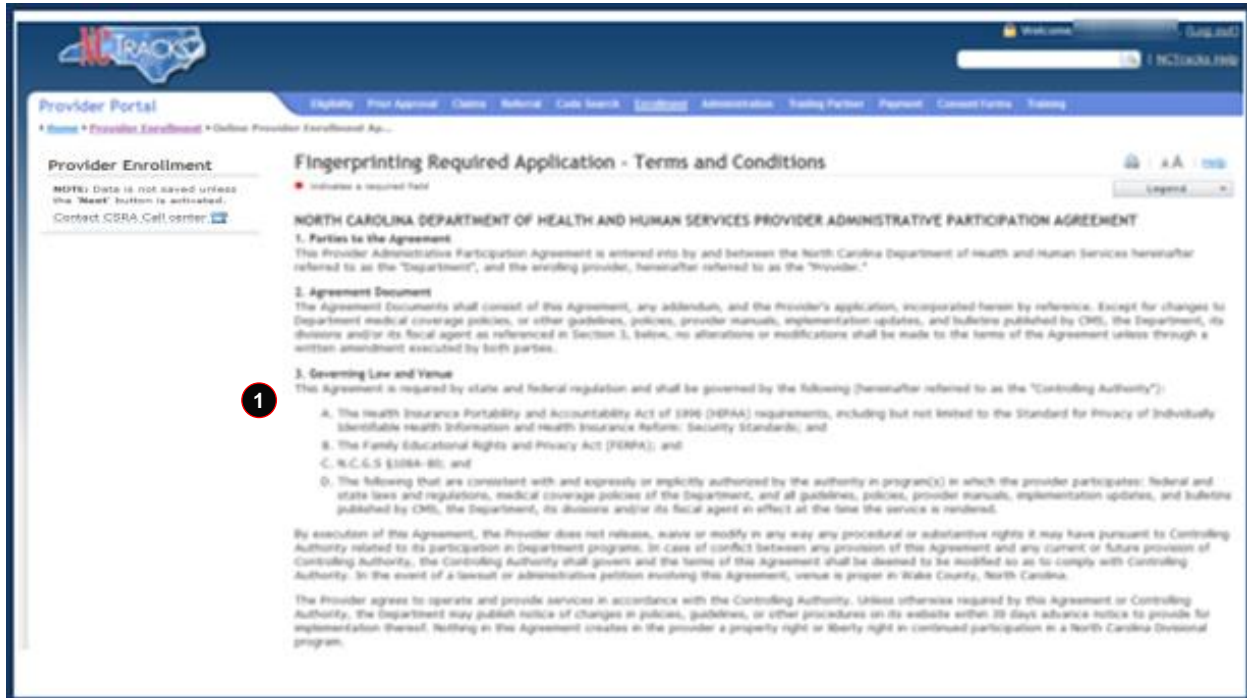


Exhibit 72. Status and Management Page – Fingerprinting Required Section

Step	Action
1	Select the radio button next to the record for which you want to begin a Fingerprinting Required application.
2	Select the Fingerprinting button.



Provider Enrollment

NOTE: Data is not saved unless the 'Next' button is activated.
Contact CSRA Call center: [icon]

Fingerprinting Required Application - Terms and Conditions

Indicates a required field

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDER ADMINISTRATIVE PARTICIPATION AGREEMENT

1. Parties to the Agreement
The Provider Administrative Participation Agreement is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the "Department", and the enrolling 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. Except for changes to Department medical coverage policies, or other guidelines, policies, provider manuals, implementation updates, and bulletins published by OHS, the Department, its divisions and/or its fiscal agent as referenced in Section 3, below, no alterations or modifications shall be made to the terms of the Agreement unless through a written amendment executed by both parties.

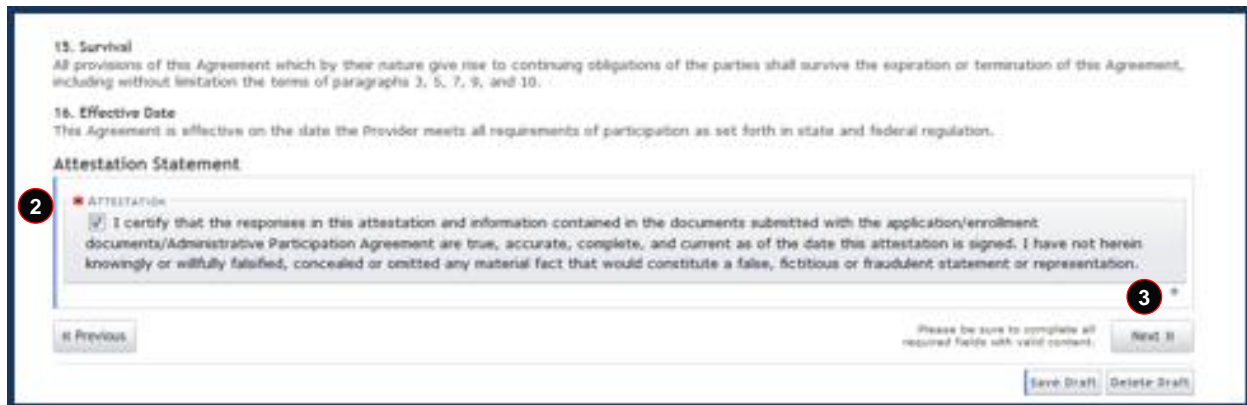
3. Governing Law and Venue
This Agreement is required by state and federal regulation and shall be governed by the following (hereinafter referred to as the "Controlling Authority"):

- A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, including but not limited to the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards; and
- B. The Family Educational Rights and Privacy Act (FERPA); and
- C. N.C.G.S §108A-80; and
- D. The following that are consistent with and expressly or implicitly authorized by the authority in program(s) in which the provider participates: federal and state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by OHS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered.

By execution of this Agreement, the Provider does not release, waive or modify in any way any procedural or substantive rights it may have pursuant to Controlling Authority related to its participation in Department programs. In case of conflict between any provision of this Agreement and any current or future provision of Controlling Authority, the Controlling Authority shall govern and the terms of this Agreement shall be deemed to be modified so as to comply with Controlling Authority. In the event of a lawsuit or administrative petition involving this Agreement, venue is proper in Wake County, North Carolina.

The Provider agrees to operate and provide services in accordance with the Controlling Authority. Unless otherwise required by this Agreement or Controlling Authority, the Department may publish notice of changes in policies, guidelines, or other procedures on its website within 30 days advance notice to provide for implementation thereof. Nothing in this Agreement creates in the provider a property right or liberty right in continued participation in a North Carolina Divisional program.

Exhibit 73. Fingerprinting Required Application – Terms and Conditions Page #1



15. Survival
All provisions of this Agreement which by their nature give rise to continuing obligations of the parties shall survive the expiration or termination of this Agreement, including without limitation the terms of paragraphs 3, 5, 7, 9, and 10.

16. Effective Date
This Agreement is effective on the date the Provider meets all requirements of participation as set forth in state and federal regulation.

Attestation Statement

2 ☒ **ATTESTATION**
I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

3 **Next**

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

Previous **Save Draft** **Delete Draft**

Exhibit 74. Fingerprinting Required Application – Terms and Conditions Page #2

Step	Action
1	Review the Fingerprinting Required Application Terms and Conditions.
2	Select the Attestation checkbox.
3	Select the Next button. The Fingerprinting Required Application – Review Application page displays.

Fingerprinting Required Application - Review Application

* indicates a required field

Legend

REVIEW APPLICATION

To review your application in Adobe PDF format, click 'Review Application' below. If you have successfully completed all required information for your provider enrollment application and are satisfied the information is complete and accurate, you may proceed to the Attachments/Submit Electronic Application page by clicking 'Next'.

1 → Review Application

2 → Next

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

Save Draft Delete Draft

Exhibit 75. Fingerprinting Required Application – Review Application Page

Step	Action
1	From the Fingerprinting Required Application – Review Application page, you can review the application in a PDF version by selecting the Review Application button.
2	Select the Next button. The Fingerprinting Required – Sign and Submit Electronic Application page displays.

Provider Portal

Eligibility Prior Approval Claims Referral Code Search Enrollment Administration Trading Partner Payment Consent Forms Training

Home Provider Enrollment Online Provider Enrollment Ap...

Provider Enrollment

NOTE: Data is not saved unless the 'Next' button is activated.
Contact CSRA Call center

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 information.

ELECTRONIC SIGNATURE CONFIRMATION

Attestation: I have read and agreed to the terms and conditions of participation. By submitting this form, I confirm the information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this electronic document is submitted. I do hereby attest that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

1 → * Login ID (NCID): [Forgot Login ID](#)

* Password: [Forgot Password](#)

2 → * PIN: [Forgot PIN](#)

Please contact the CSRA Call center at 800-688-6696 if you have any trouble with your Electronic Signature PIN Number.

Please review the documents you are going to electronically sign.

Trading Partner Agreement

ONLINE APPLICATION SUBMISSION

You may now submit your Online Application by clicking 'Submit Now' below. After submitting you will have the option to print a copy of the completed application for your records.

You will also receive instructions to finalize the application process on the next page.

Submit Later 3 → Submit Now

Previous Delete Draft

Exhibit 76. Fingerprinting Required Application – Sign and Submit

Step	Action
1	Enter the NCID and Password that were initially used to log in to the NCTracks Secure Provider Portal.
2	Enter the 4-digit Electronic Signature PIN .
3	Select Submit Later to save the application as a draft to be submitted at a later time. Select Submit Now to submit the application now.

Exhibit 77. Fingerprinting Required Application – Final Steps Page

Step	Action
1	The Final Steps page provides links to PDF versions of the Online Application and Cover Sheet to be used in the event that you choose to mail or e-mail supporting documentation. These documents must be printed or saved before you navigate away from this page; otherwise, you will not have access to them again.
2	The Fingerprinting Required section provides information on the next step of the fingerprinting process. The OA will be contacted via e-mail and through the Message Center inbox with further instructions.
3	The Upload Documents button allows you to attach documents directly to the application.

Enrollment Ap...

Upload Documents

• indicates a required field

Legend

1 Notification

1. For Work Gap: If uploading a work gap history explanation, ensure the letter is signed by the provider AND dated.
2. For Exclusion/Sanction: If uploading an explanation for an affirmative exclusion sanction response, ensure the letter is signed and dated. The letter must be signed by the provider, the person with the infraction, or the Office Administrator (OA). The letter must also be dated within the past six months of the application submission date.
3. For Transcripts: Do not upload transcripts here. The official nature of school transcripts requires them to be submitted through the secure email address (ProxControlSupport@odit.com) or mail (Provider Enrollment, PO Box 300009, Raleigh, NC 27622) and only by the school. Providers should contact the school where they completed their highest education and request the school send a transcript through the secure email or mail.
4. For DEA Designation, NEMT, SLJ, OOS-DME forms: The form must be signed AND dated by the provider or the OA.

Electronic Attachments

Only one file can be uploaded at a time. Maximum 20 files can be uploaded per application. A File cannot be more than 25 MB.
The following file types may be attached: MS-Word, MS-Excel, WordPerfect, MS-Write, Open Office, text, Power Point, Zip, PageMaker, Adobe PDF, image(TIFF, JPEG, GIF, PNG).

To upload a file:

1. Click the 'Browse/Choose File' button.
2. Locate the file and add. Note: The file name will display to the right of the 'Browse/Choose File' button.
3. Click the Upload Document button to submit the file to NCTracks.
4. When upload is successful, a message will be displayed with the file name. If you wish to print a record of submitted attachments, click the printer icon located at the right hand corner of the screen.

2 General Enrollment Additions

Upload general enrollment documents related to the application here. Do not upload fingerprinting documents here. Maximum 20 files can be uploaded per application.

3 Choose File No file chosen

4 Upload Document

Return to Provider Enrollment Status and Management Page

Exhibit 78. Fingerprinting Required Application – Upload Documents Page

Step	Action
1	Information is provided on the types of documents that can be uploaded as well as step-by-step instructions.
2	The General Enrollment Additions section is used to electronically attach supporting documents not related to fingerprinting. Note: Fingerprinting documents uploaded in this section will not be processed.
3	Select the Choose File button to locate and upload your General Enrollment supporting documents.
4	Select the Upload Document button to add the selected document. Repeat the process for each additional document.

Upload Documents

* indicates a required field

1 NCTracks Success

File 02022015 CSR 1635 Status.txt is uploaded to NCTracks successfully.

ELECTRONIC ATTACHMENTS

Only one file can be uploaded at a time. Maximum 20 files can be uploaded per application. A File cannot be more than 25 MB.
The following file types may be attached: MS-Word, MS-Excel, WordPerfect, MS-Write, Open Office, text, Power Point, Zip, PageMaker, Adobe PDF, image(TIFF, JPEG, GIF, PNG).

To upload a file:

1. Click the Browse button.
2. Locate the file and add. Note: The file name will display to the right of the Browse button.
3. Click the Upload Document button to submit the file to NCTracks.
4. When upload is successful, a message will be displayed with the file name. If you wish to print a record of submitted attachments, click the printer icon located at the right hand corner of the screen.

Uploaded File(s)
02022015 CSR 1635 Status.txt

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

Exhibit 79. Fingerprinting Required Page – Document Uploaded Successfully

Step	Action
1	A confirmation page will be received after the successful submission of electronic attachments.

If required fingerprinting documents are not received in the initial 30 days, the application will be abandoned and the provider's Medicaid, DPH, and ORH health plans will be terminated. If these are the only health plans on the provider record, a Re-enrollment application will be required.

If the provider has been given extensions to submit correct supporting documentation and the information submitted is deemed inadequate, the provider's Medicaid, DPH, and ORH health plans will be terminated. If these are the only health plans on the provider record, a Re-enrollment application will be required.

9.0 Resources

9.1 RESOURCES

For more information, please refer to the *Updating Provider Records* CBT on SkillPort.

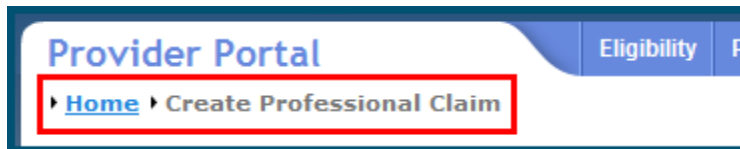
This Page Intentionally Left Blank

Addendum A. Help System

The major forms of help in the NCMMIS NCTracks system are as follows:

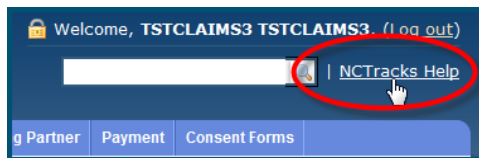
- Navigational breadcrumbs
- System-Level Help – Indicated by the “NCTracks Help” link on each page
- Page-Level Help – Indicated by the “Help” link above the Legend
- Legend
- Data/Section Group Help – Indicated by a question mark (?)
- Hover-over or Tooltip Help on form elements

Navigational Breadcrumb



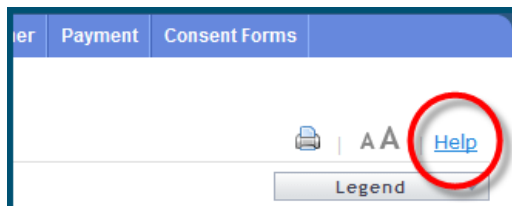
A breadcrumb trail is a navigational tool that shows the path of pages that the user has visited from the home page. This breadcrumb consists of links so the user can return to specific pages on this path.

System-Level Help



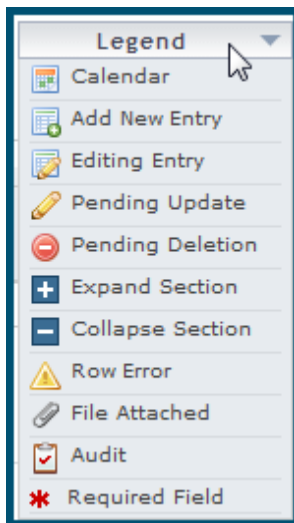
The System-Level Help link opens a new window with the complete table of contents for a given user's account privileges. The System-Level Help link, “NCTracks Help”, will display at the top right of any secure portal screen or web application form screen that contains Screen-Level and/or Data/Section Group Help.


Page-Level Help



Page-Level Help opens a modal window with all of the Data/Section Group help topics for the current page. The Page-Level Help link displays across from the page title of any web application form page.

Form Legend



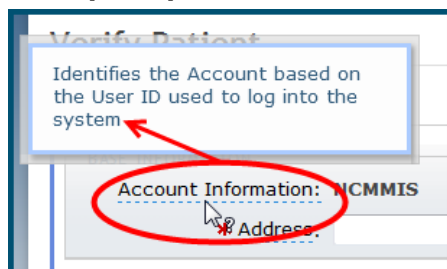
A legend of all helpful icons is presented on pages as needed to explain the relevant meanings. This helps the user become familiar with any new icon representations in context with the form or page as it is used. Move the mouse over the Legend icon  to open the list.

Data / Section Group Help

A screenshot of a form titled 'PATIENT INFORMATION'. The form contains several input fields: '* Recipient ID:', '* SSN:', '* Date of Birth:', 'Date of Service', '* From:', and '* To:'. There are also 'Verify' and 'Clear' buttons at the bottom right. A red circle highlights a question mark icon in the top right corner of the form, and another red circle highlights a question mark icon in the 'Date of Birth' field.

Data/Section Group Help targets the same modal window as Page-Level help, but also targets specific form information associated with the Help link that the user selected. Data/Section Group Help displays as a question mark (?).

Tooltip Help




Tooltip help is available via a popup box that appears slightly above the page element when a user hovers the cursor over the element. Text with an available tooltip has a dashed underline.

Addendum B. PayPoint Process

The PayPoint screen displays after you select **Pay Now** from the [Final Steps page](#) or the [Status and Management page](#).

Exhibit 80. PayPoint Screen

Step	Action
1	<p>Select Pay by electronic check or Pay by credit card.</p> <ul style="list-style-type: none"> If you select Pay by credit card, the Payment Information – Credit Card screen displays. If you select Pay by electronic check, select Personal or Business as the Account Type; the Payment Information – Pay by Check screen displays. Note: The \$100 Provider Application Fee has been reinstated for all Enrollment and Re-verification applications effective July 1, 2023.



Provider Enrollment

Language: English


Payment Information

* Indicates required field

- #### Billing Address

*First Name:
M.I.:
*Last Name:
*Street Line 1:
Street Line 2:
*City:
*State:
*Zip:
Phone:
E-Mail:
- #### Payment Details


*Payment Amount: 100.00 USD
- #### Payment Method

*Name as it Appears on Card:
*Card Number:
*Expiration Date:

* Enter the above code:
[Can't read? Try a different code.](#)

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Powered by PayPoint®

Exhibit 81. Payment Information – Credit Card Screen

Step	Action
1	Enter the information for the Billing Address fields.
2	Payment Details: Displays Payment Amount .
3	Enter Payment Method fields: Name as it Appears on Card , Card Number , Expiration Date , and Enter the above code .



Provider Enrollment

Language: English

Payment Information

* Indicates required field

1

Billing Address

* First Name: M.I.: * Last Name:

* Street Line 1:

Street Line 2:

* City:

* State: Select State

* Zip:

Phone:

E-Mail:

2

Payment Details

* Payment Amount: 100.00

Your account will be debited in 1 to 3 days from the date identified. If your payment date falls on a non-banking date your payment will be executed on the next available banking day. Current date payments received 4:00 PM MT will be executed on the next valid banking date.

3

Payment Method

* Name On Account:

* Account Number: [What's This?](#)

* Re-Type Account Number:

* Routing Number: [What's This?](#)

* Account Type: ☒ Checking ☐ Savings

4

5

Exhibit 82. Payment Information – Pay by Check Screen

Step	Action
1	Billing Address: Enter the information for the Billing Address fields.
2	Payment Details: Displays Payment Amount .
3	Enter Payment Method fields: Name On Account , Account Number (Retype) , Routing Number , and Account Type (select Checking or Savings).
4	Select the Back button to change Payment Type, the Next button to display the Payment Review screen, or the Exit button to close the PayPoint screen.
5	Select the Next button. The Payment Review screen displays.

Provider Enrollment

Language: English

Payment Review

Address
Billing Address:

Payment Method
Credit Card

Payment Amount
Amount: 100.00 USD
Total: 100.00 USD

1 Back 2 Pay Now Exit

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Exhibit 83. Payment Review Screen

Step	Action
1	Select the Back button to change payment details, the Pay Now button to submit payment, and the Exit button to close the PayPoint screen.
2	After selecting the Pay Now button, you are redirected to the NCTracks portal to the Payment Confirmation page. Note: You will also receive an e-mail with a copy of the confirmation.

Payment Confirmation

* indicates a required field

Legend

PAYMENT CONFIRMATION DETAILS

Below is your payment summary and confirmation; please print the page for your records.
Payments are posted and the payment status will be updated within 2 business days of being received.
Contact the CSRA Call Center at 800-688-6696 if you have any questions about this payment.

Confirmation Number:

NPI/Atypical ID:

Provider Name:

Payment Amount: \$100.00

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

Exhibit 84. Payment Confirmation Screen

Addendum C. NC Application Fee and Federal Requirements

Application Type	NC Application Fee (\$100)	Federal Fee	Federal Site Visit	Federal Training
Enrollment	Always required when provider applied for Medicaid. Exclusion: OOS Lite providers.	Federal Fee is required per location when one or more Federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid health plans only.	Federal Site Visit is required per location when one or more Federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid health plans only.	Always required when provider applied for Medicaid.
Re-enrollment	Never required.	Federal Fee is required per location when one or more Federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid health plans only.	Federal Site Visit is required per location when one or more Federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid health plans only.	Never required
Manage Change Request	Only required when an OOS Lite provider upgrades to OOS Full provider.	Federal Fee is required per newly added/reinstated location when one or more Federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid health plans only.	Federal Site Visit is required per newly added/reinstated location when one or more Federal taxonomy codes (as identified on the Permission Matrix) are added. Note: Medicaid health plans only.	Never required

Application Type	NC Application Fee (\$100)	Federal Fee	Federal Site Visit	Federal Training
Re-verification	Always required when provider is active in Medicaid.	Federal Fee is required by location when one or more federal taxonomy codes (as identified on the Provider Permission Matrix) are active. Note: Medicaid health plan only.	Federal site visit is required per location when one or more federal taxonomy codes (as identified on the Provider Permission Matrix) are active.	Never required
Abbreviated MCR	Never required	Never required	Never required	Never required
Change Office Administrator	Never required	Never required	Never required	Never required
Maintain Eligibility	Never required	Never required	Never required	Never required
Fingerprinting	Never required	Never required	Never required	Never required