CSRA

a General Dynamics Information Technology, Inc. company

NCMMIS
Human Service Organization Enrollment
Participant User Guide

PREPARED FOR:

North Carolina Department of Health and Human Services

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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
V2.0	October 27, 2022	Final version
D2.0.1	October 21, 2022	Update for CSR2481
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D1.0.1	November 22, 2021	Initial submission

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1.0 Welcome

1.1 COURSE OVERVIEW

Welcome to this course on Human Service Organization (HSO) Provider Enrollment. This course will guide users through the process of completing a Human Service Organization Provider initial enrollment application in the NCTracks Provider Portal.

1.2 COURSE BENEFITS

This course will guide users through an overview of the initial Enrollment process for Human Service Organization providers.

1.3 COURSE OBJECTIVES

At the end of this training, users will be able to understand the Provider Enrollment Application process, navigate to the NCTracks Provider Portal, and complete the HSO Provider Enrollment Application process.

1.4 PREREQUISITES

None.

NOTES:

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2.0 Human Services Organization Applications

2.1 INTRODUCTION

This course will guide users through the process of completing a Human Service Organization Provider enrollment application in the NCTracks Provider Portal.

- Initial Enrollment – You will complete an initial Enrollment application if you want to newly enroll with NC DHHS.
- Re-verification – Most providers are required to provide a Re-verification application every 5 years; however, atypical providers with HSO-only taxonomy codes are exempt from Re-verification.
- 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

Trainees will view demonstrations of completing the above applications. This Participant User Guide will also provide step-by-step documentation of the processes to complete and submit 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**.

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 screen
- Screen-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.

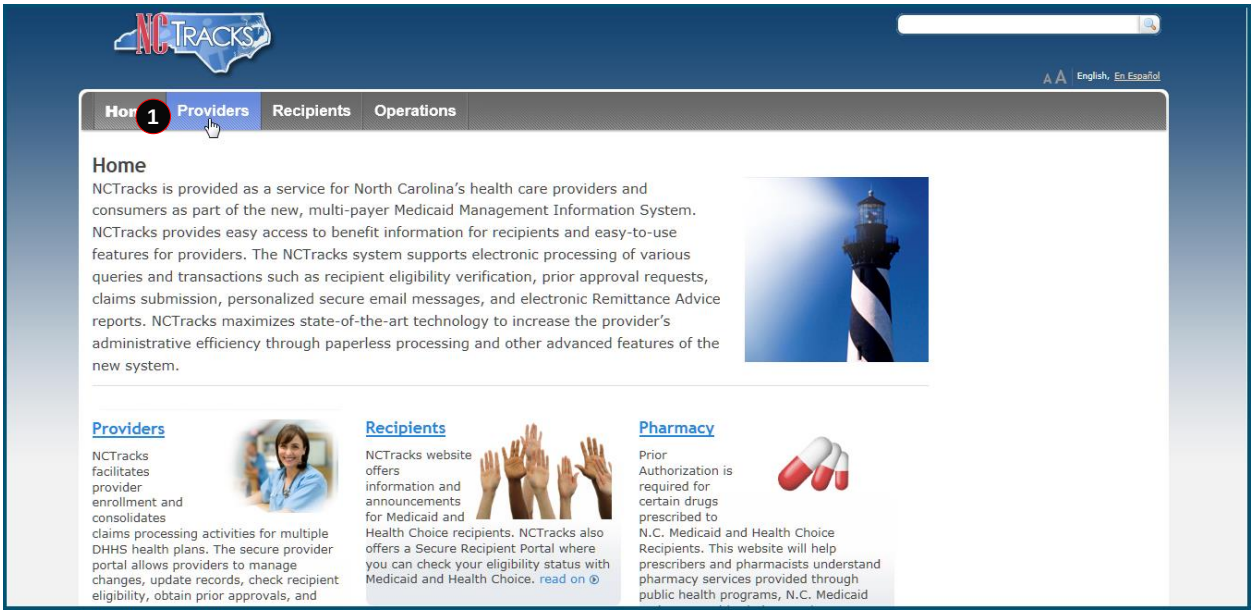


Exhibit 1. NCTracks Home Page

Step	Action
1	Select the **Providers** link. The public **Providers** page displays.

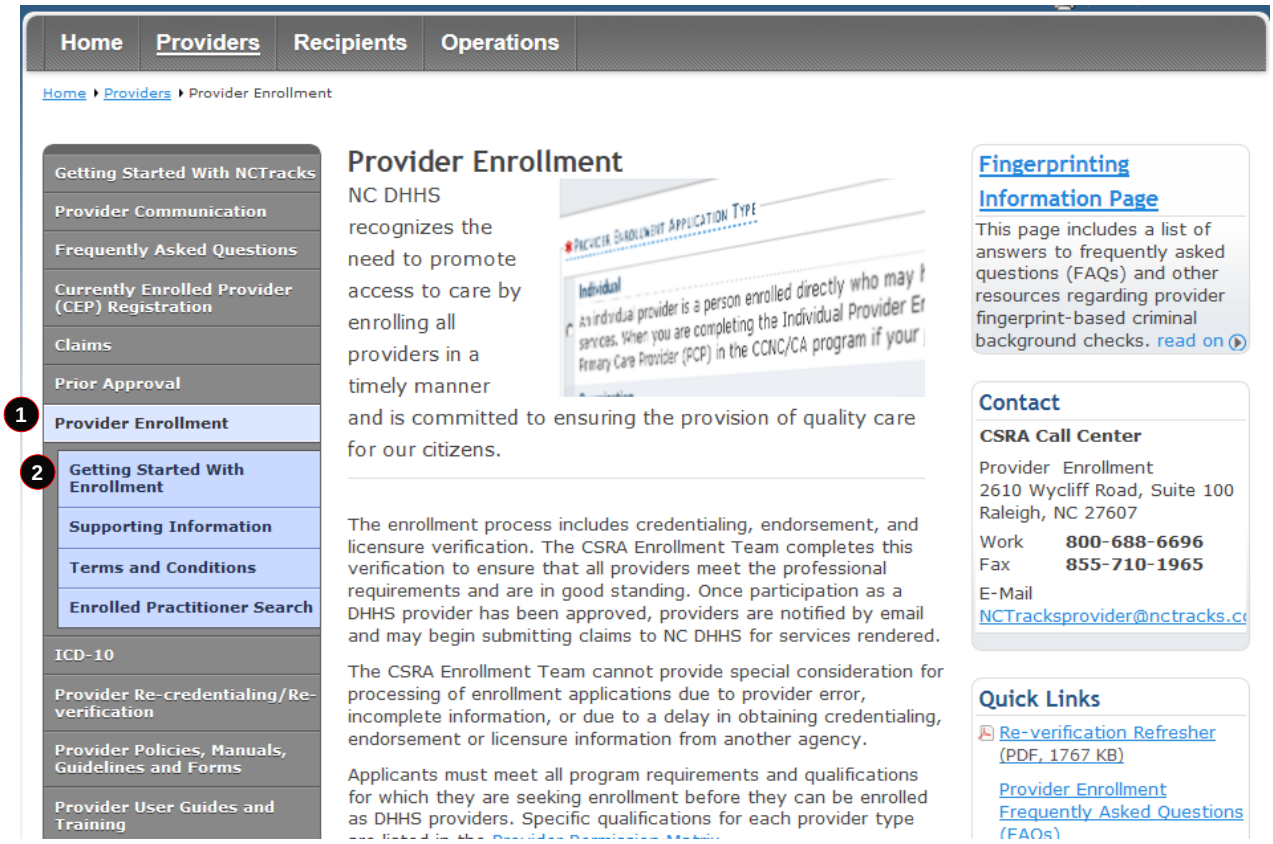


Exhibit 2. Public Providers Page

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

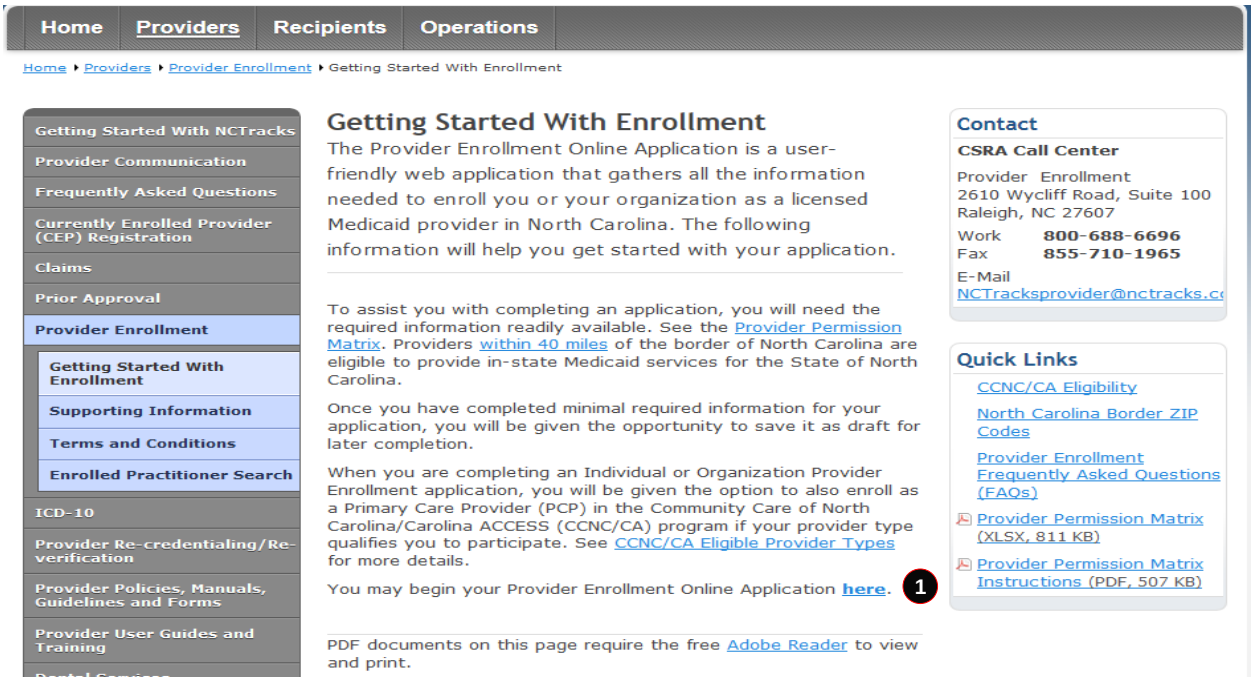


Exhibit 3. Getting Started Page

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

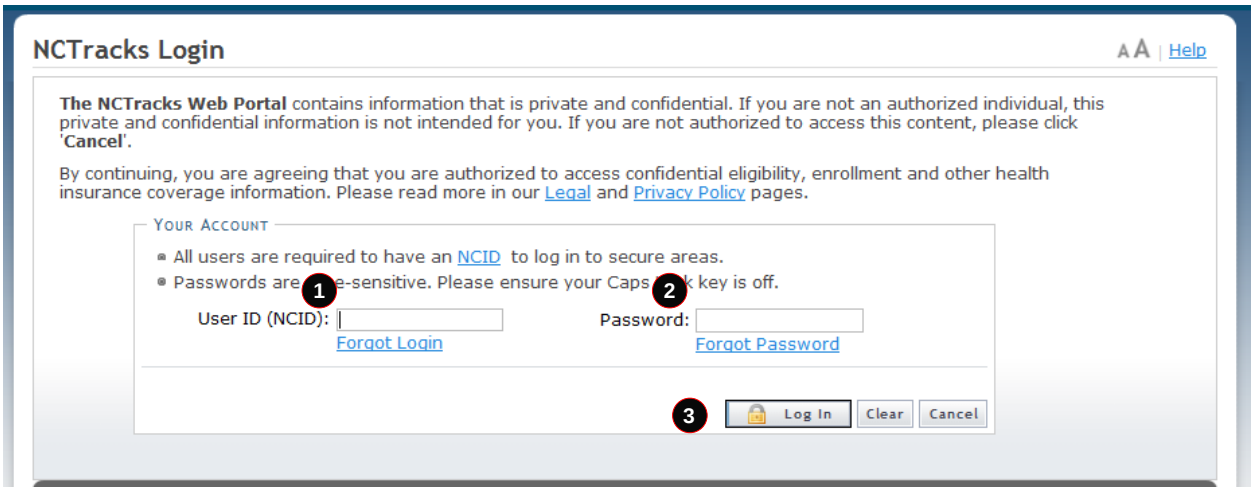


Exhibit 4. NCTracks Login Page

Step	Action
1	User ID (NCID): Enter your **NCID**. **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 *Enrollment Specialist User*.
2	Password: Enter your **Password**.
3	Select the **Log In** button. The Provider Portal displays.

Step	Action
Note	Select the **NCID** link only if provider (the OA) does not have an NCID. Once on the North Carolina Identity Management (NCID) website, click Register. The new User registration page will display. Select Individual. Fill out all of the required fields • Desired username • First Name • Last Name • Email Address • Mobile Number (Not Required but recommended) • New password – Password is case sensitive. – Must be at least 8 characters long. – Must not include part of your name or user name. – Must not include a common word or commonly used sequence of characters. – Can be changed no more often than once every 3 days. – Must have at least 3 of the 5 character types below: • Uppercase (A-Z) • Lowercase (a-z) • Number (0-9) • Symbol (!, #, $, etc.) • Other language characters not listed above • New password may not have been used previously. Click **Continue**.
Note	Passwords are case-sensitive. After three unsuccessful attempts, the user will be locked out; however, NCTracks will provide a contact number that the user can call for access assistance. Multi-Factor Authentication (MFA) is required. After the user enters the user ID and password, the second level authentication will be sent to the user's preferred method (Phone or Mobile App). For more information on the MFA registration process, please refer to the *Provider Multi-Factor Authentication Registration Process* job aid located in SkillPort.

3.2 ONLINE PROVIDER ENROLLMENT APPLICATION PAGE

On the **Online Provider Enrollment Application** page, you will enter your ZIP code for the administrative office for the HSO's Healthy Opportunities Pilots work 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**.

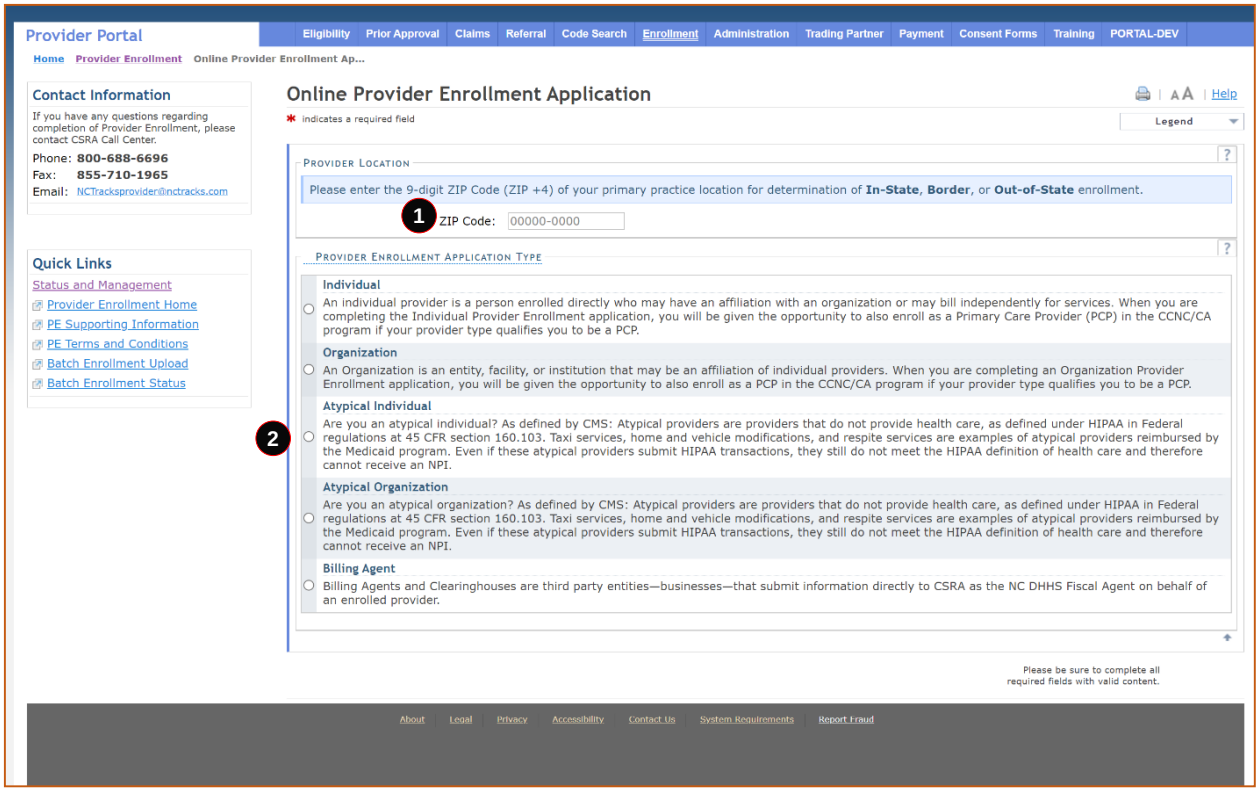


Exhibit 5. Online Provider Enrollment Application Page

Step	Action
1	ZIP Code: Enter your **ZIP Code**.
2	Provider Enrollment Application Type: Select **the applicable application type**.

3.3 ORGANIZATION BASIC INFORMATION PAGE

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

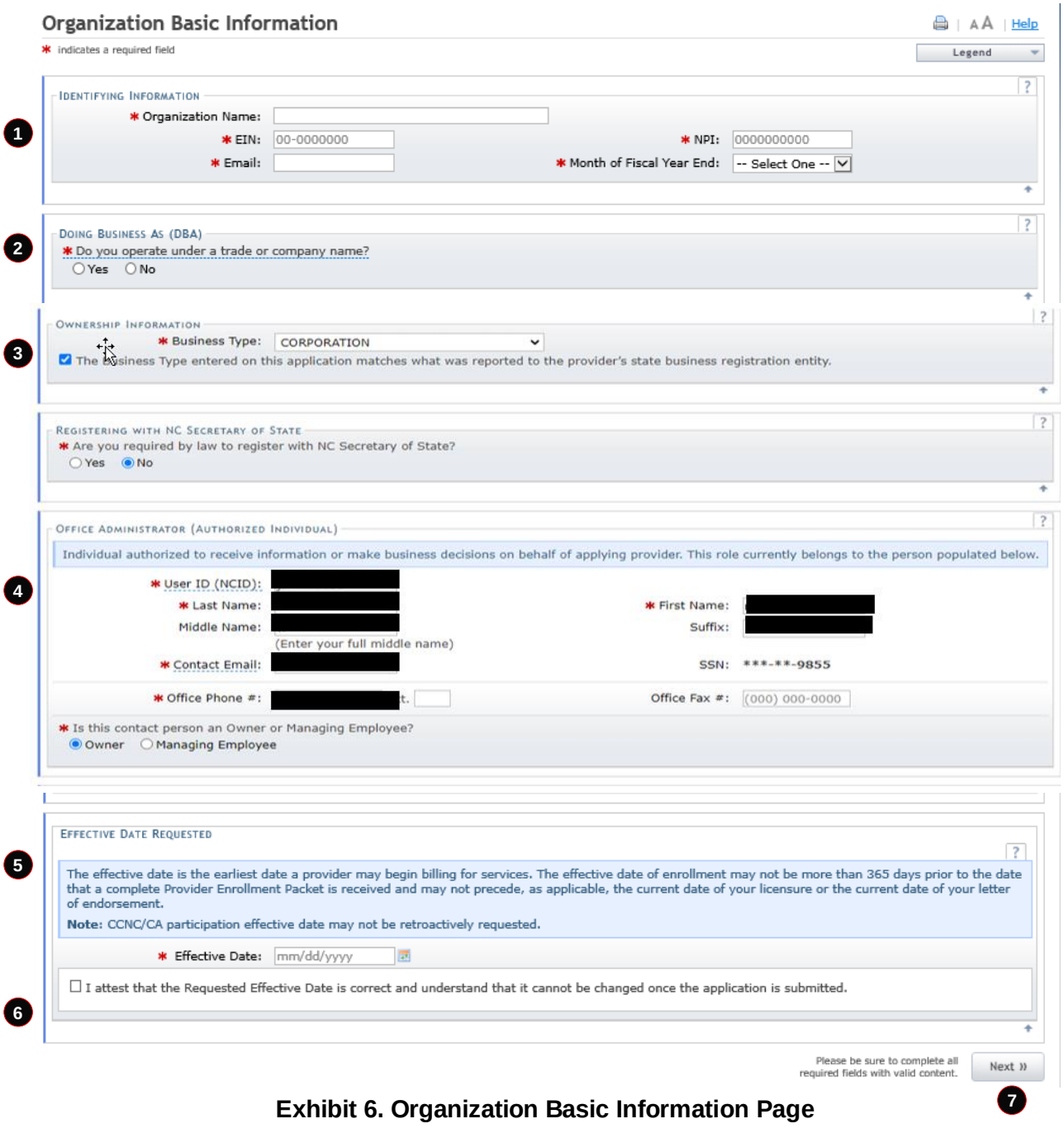
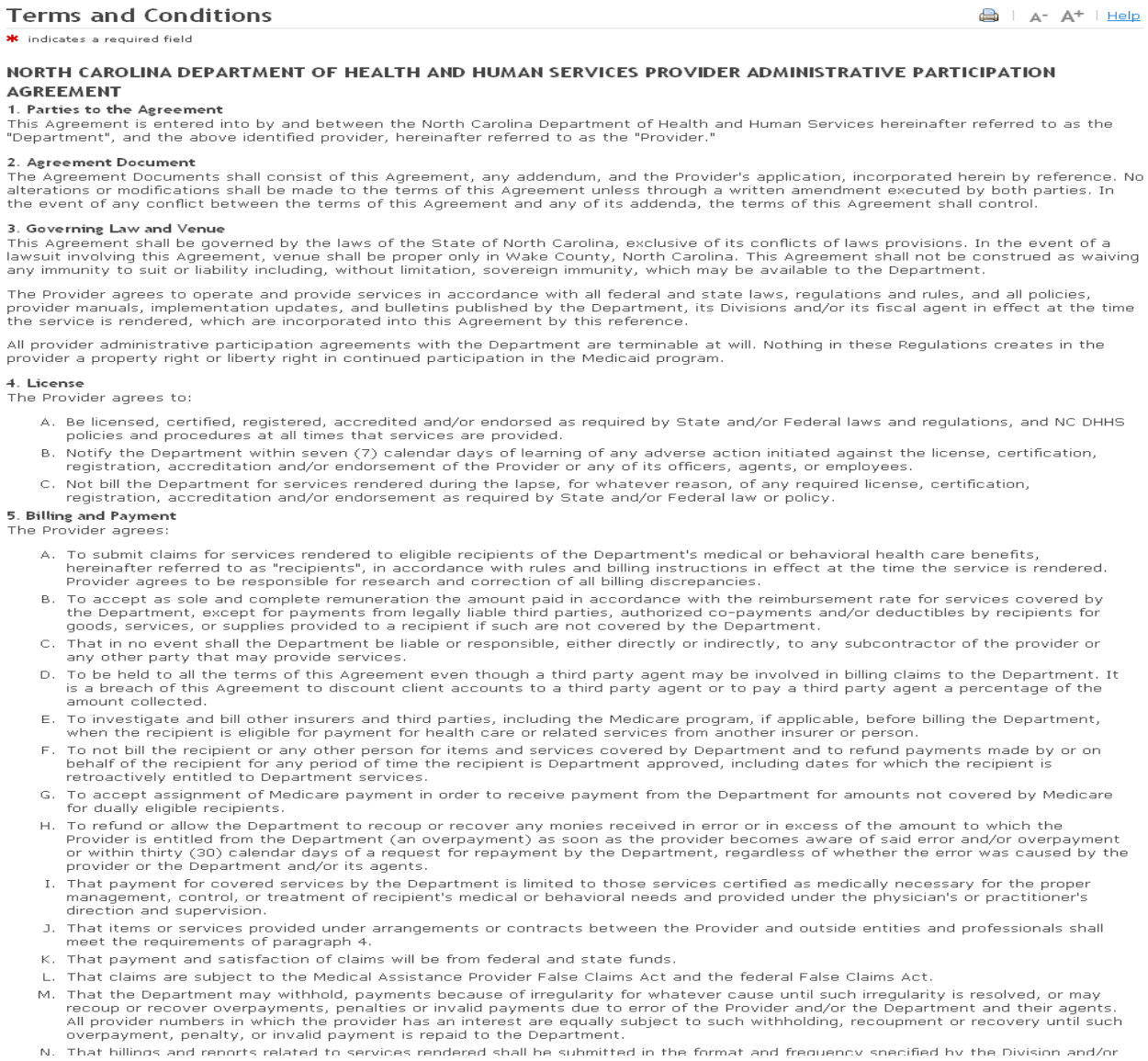


Exhibit 6. Organization Basic Information Page

Step	Action
1	Identifying Information: Enter **Organization Name**, **EIN**, **NPI**, **Email**, and **Month of Fiscal Year End**.
2	Doing Business As (DBA): Answer **Yes** or **No** to the question: **"Do you operate under a trade or company name?"**. • 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.
3	Ownership Information: Select the **Business Type** from the drop-down menu: • **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. • **Ownership Information:** It is important to note that you will now have to check the box stating that the business type selected on this application matches what was reported to the provider's state business registration entity. The provider must review and attest to this attestation statement on all Enrollment, Re-enrollment, Manage Change Request, and Reverification applications when a provider is electing a business type.
Note	The **Organization Name** and **DBA Name** fields only allow the following characters: • Alpha (A – Z) • Numeric (0 – 9) • Hyphen (-) • Ampersand (&) 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: • Alpha (A – Z) • Numeric (0 – 9) • Hyphen (-) • Ampersand (&)
4	Office Administrator (Authorized Individual): Enter **Last Name**, **First Name**, **Contact Email**, **Office Phone #**, and **User ID (NCID)**.
5	Effective Date Requested: Enter earliest HSO-NL contract Effective Date.
6	Check box beside Attestation: **I attest that the requested effective date is correct and understand that it cannot be changed once the application is submitted**.
7	Select **Next**.

3.4 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.



Terms and Conditions

A- A+ | Help

* indicates a required field

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, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.
C. Not bill the Department for services rendered during the lapse, for whatever reason, of any required license, certification, registration, accreditation and/or endorsement as required by State and/or Federal law or policy.

5. Billing and Payment
The Provider agrees:

A. To submit claims for services rendered to eligible recipients of the Department's medical or behavioral health care benefits, hereinafter referred to as "recipients", in accordance with rules and billing instructions in effect at the time the service is rendered. Provider agrees to be responsible for research and correction of all billing discrepancies.
B. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered by the Department, except for payments from legally liable third parties, authorized co-payments and/or deductibles by recipients for goods, services, or supplies provided to a recipient if such are not covered by the Department.
C. That in no event shall the Department be liable or responsible, either directly or indirectly, to any subcontractor of the provider or any other party that may provide services.
D. To be held to all the terms of this Agreement even though a third party agent may be involved in billing claims to the Department. It is a breach of this Agreement to discount client accounts to a third party agent or to pay a third party agent a percentage of the amount collected.
E. To investigate and bill other insurers and third parties, including the Medicare program, if applicable, before billing the Department, when the recipient is eligible for payment for health care or related services from another insurer or person.
F. To not bill the recipient or any other person for items and services covered by Department and to refund payments made by or on behalf of the recipient for any period of time the recipient is Department approved, including dates for which the recipient is retroactively entitled to Department services.
G. To accept assignment of Medicare payment in order to receive payment from the Department for amounts not covered by Medicare for dually eligible recipients.
H. To refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the provider or the Department and/or its agents.
I. That payment for covered services by the Department is limited to those services certified as medically necessary for the proper management, control, or treatment of recipient's medical or behavioral needs and provided under the physician's or practitioner's direction and supervision.
J. That items or services provided under arrangements or contracts between the Provider and outside entities and professionals shall meet the requirements of paragraph 4.
K. That payment and satisfaction of claims will be from federal and state funds.
L. That claims are subject to the Medical Assistance Provider False Claims Act and the federal False Claims Act.
M. That the Department may withhold, payments because of irregularity for whatever cause until such irregularity is resolved, or may recoup or recover overpayments, penalties or invalid payments due to error of the Provider and/or the Department and their agents. All provider numbers in which the provider has an interest are equally subject to such withholding, recoupment or recovery until such overpayment, penalty, or invalid payment is repaid to the Department.
N. That billings and reports related to services rendered shall be submitted in the format and frequency specified by the Division and/or

Exhibit 7. Terms and Conditions Page

3.5 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.

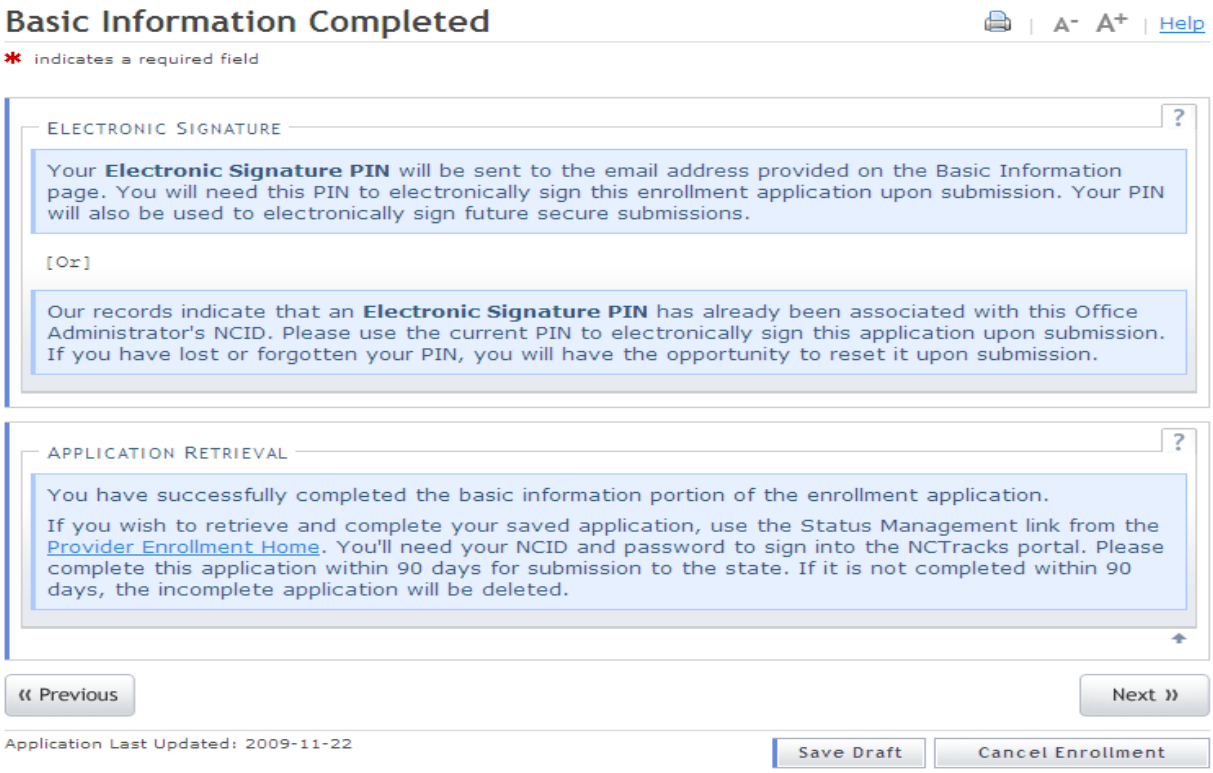


Exhibit 8. Basic Information Completed Page

3.6 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.

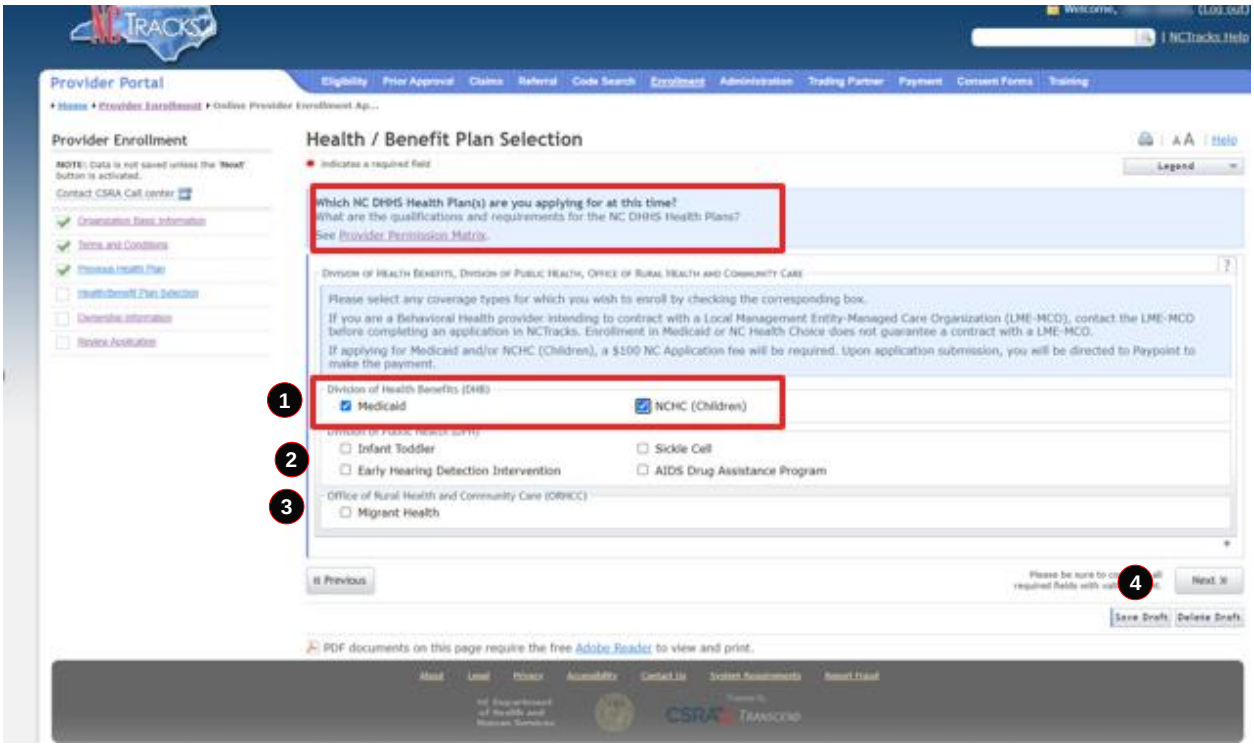


Exhibit 9. Health / Benefit Plan Selection Page

Step	Action
1	This section includes Division of Health Benefits (DHB): **Medicaid** and **NCHC (Children)**. Do not opt out of coverage under DHB.
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 **AIDS Drug Assistance Program**.
3	Opt out of any coverage by deselecting the appropriate checkbox: Office of Rural Health and Community Care (ORHCC): **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 plans: **Medicaid** and **NCHC (Children)**.

3.7 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 **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 (see Section 3.8).

Note: OOS Organizations only see the **Ownership Information** page when the OA is an owner. No other owners can be added to the record.

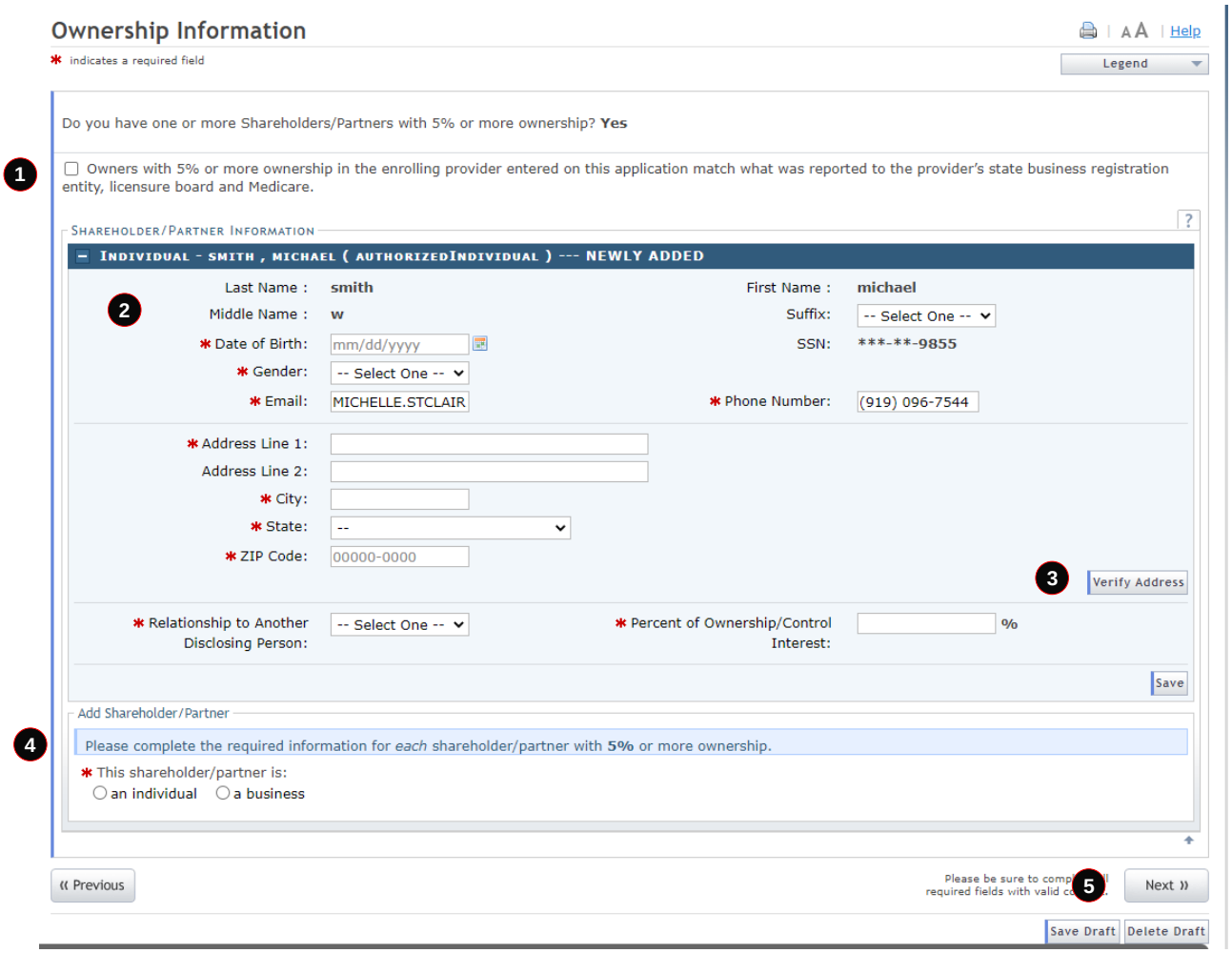


Exhibit 10. Ownership Information Page

Step	Action
1	Shareholder/Partner Information: Do you have one or more Shareholders/Partners with 5% or more ownership?: Select **Yes** or **No** and the attestation box. *Owners with 5% or more ownership in the enrolling provider entered on this application must match what was reported to the provider's state business registration entity, licensure board and Medicare and check the box.*
2	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**.
3	Then select the **Verify Address** button and then **Save** button.
4	Add Shareholder/Partner: • For 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 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.

3.8 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.

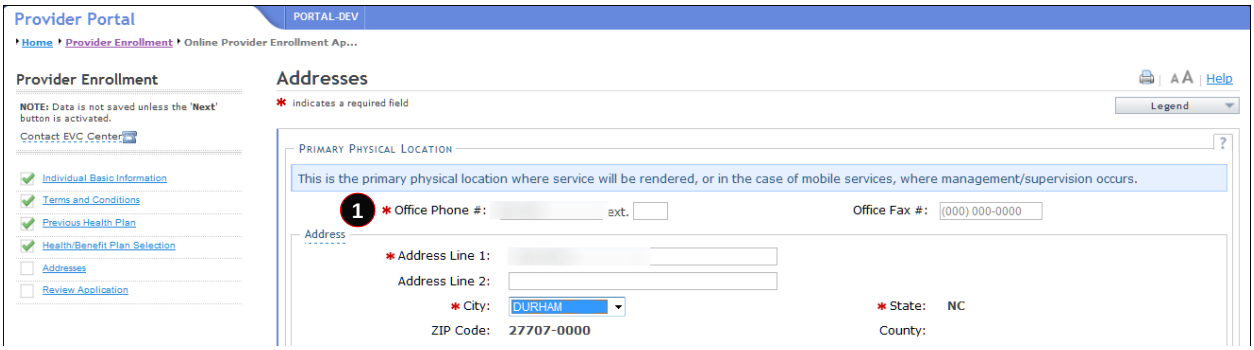


Exhibit 11. Addresses Page #1

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).

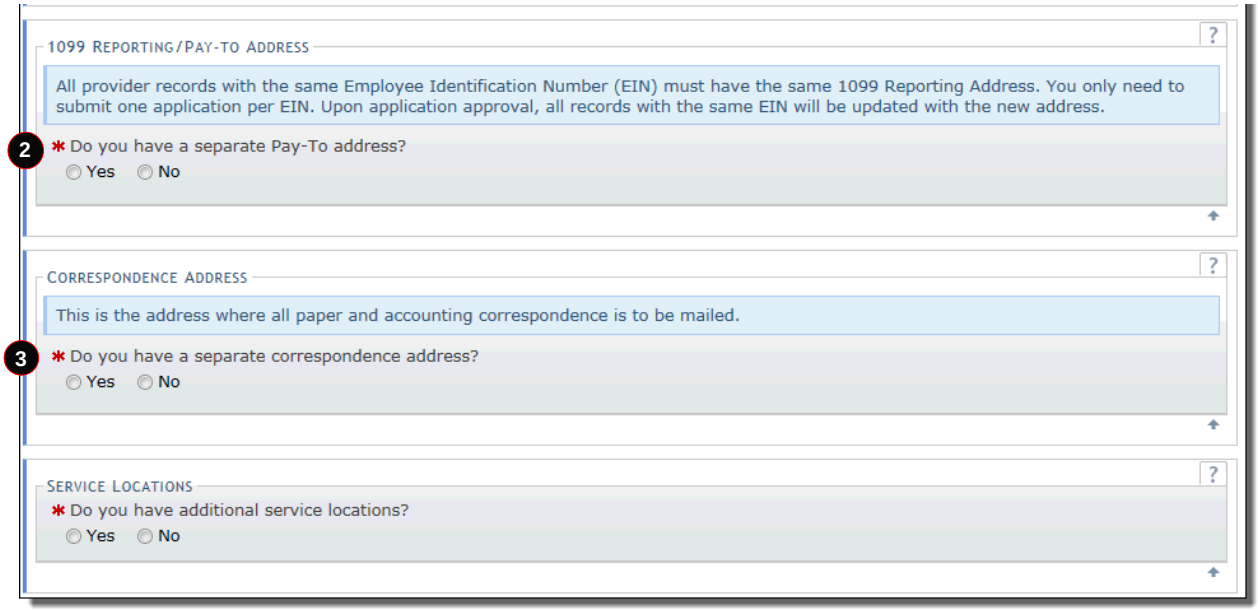


Exhibit 12. Addresses Page #2

Step	Action
2	Servicing Counties: You must select the checkboxes for all counties in which you will render services.
3	1099 Reporting/Pay-To Address: Do you have a separate Pay-To address?; Select **Yes** or **No**.

Step	Action
	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.

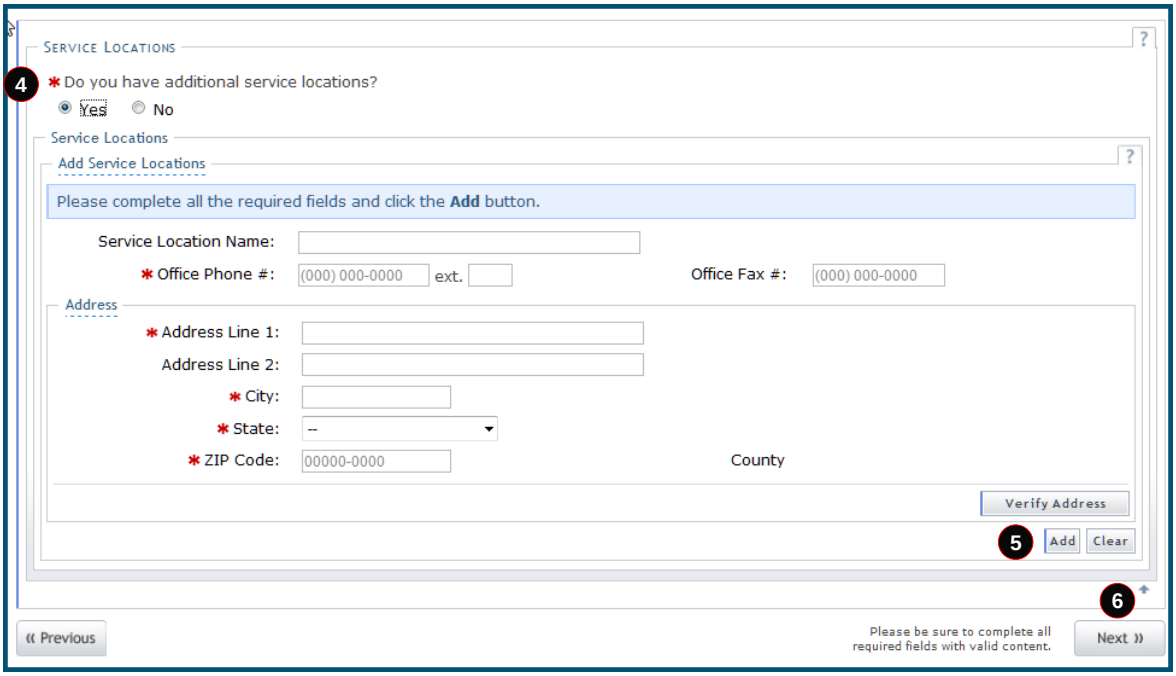
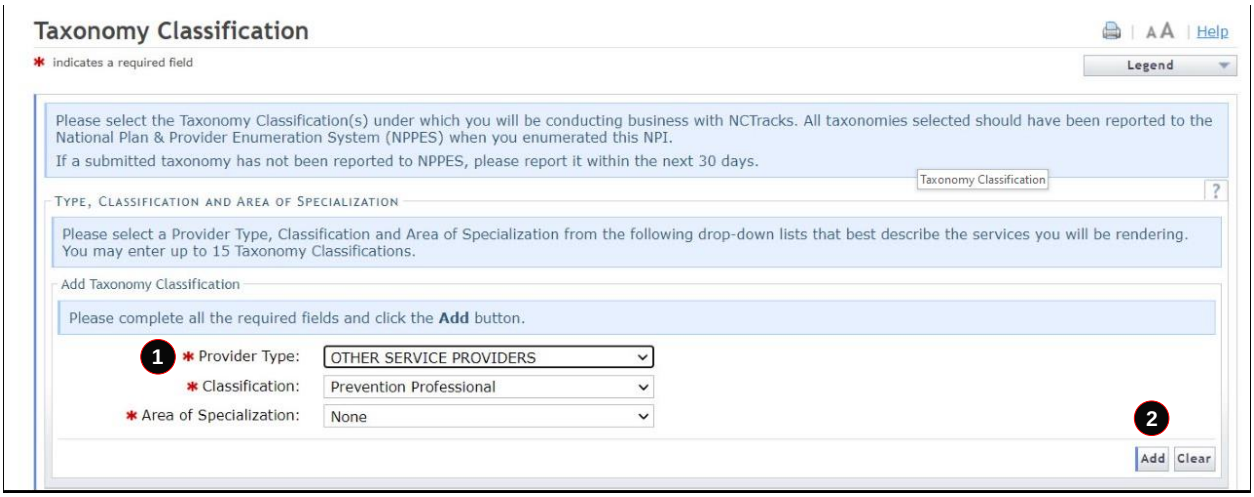


Exhibit 13. Addresses Page #3

Step	Action
4	Service Locations: Do you have additional service locations? Select **Yes** or **No**. If **Yes**, enter **Office Phone #**, **Address**, **City**, **State**, and **ZIP Code**.
5	Select the **Add** button to add the service location.
6	Select the **Next** button to continue.
Note	HSOs providing services in multiple Pilot regions should indicate the offices in each of the regions, if applicable.

3.9 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.



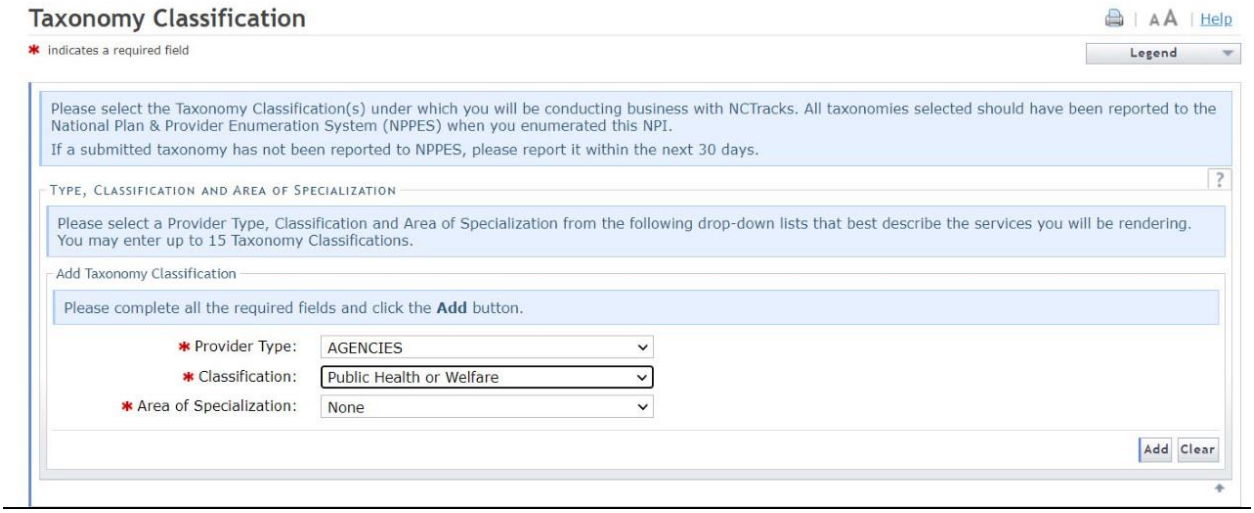


Exhibit 14. Taxonomy Classification Page

Step	Action
1	Add Taxonomy Classification: Using the drop-down menus, select **Provider Type**, **Classification**, and **Area of Specialization** (if applicable). If you are enrolling as an individual or atypical individual provider, select the following: • **Provider Type:** Other Service Providers • **Classification:** Prevention Professional • **Area of Specialization:** None If you are enrolling as an organization or an atypical organization, select the following: • **Provider Type:** Agencies • **Classification:** Public Health or Welfare • **Area of Specialization:** None
2	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.

3.10 HSO SERVICES PAGE

The **HSO Services** page captures services information. This page displays only for Human Services Organizations.

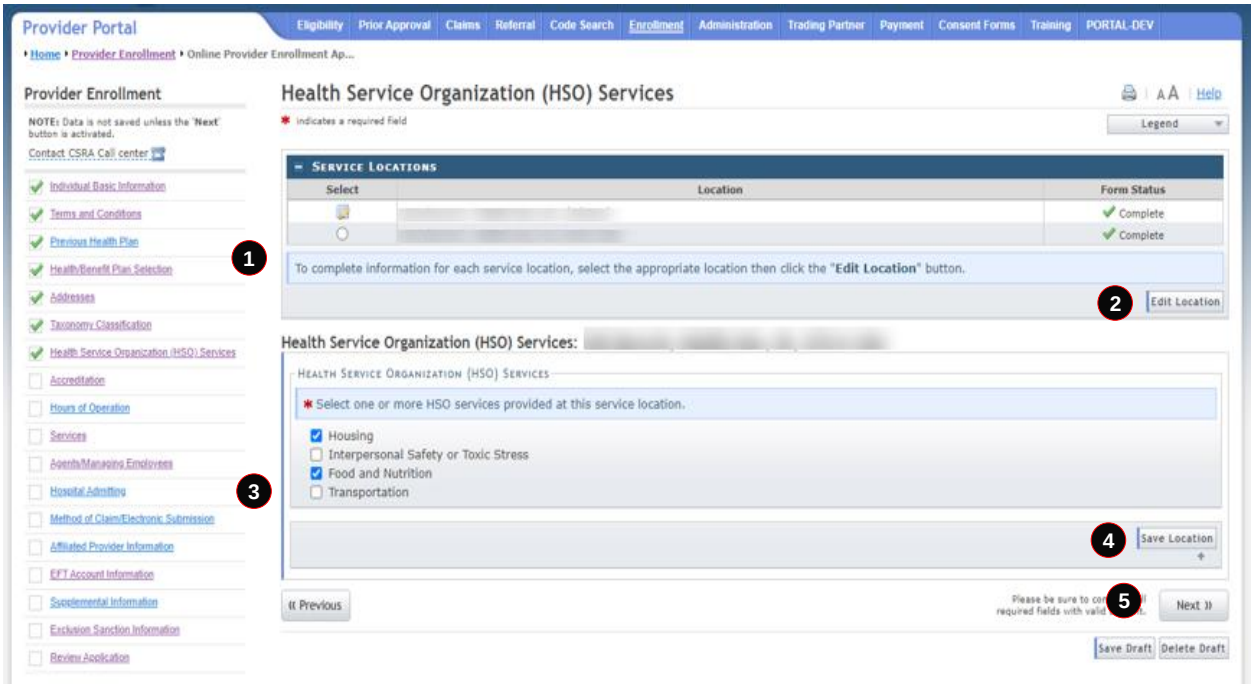


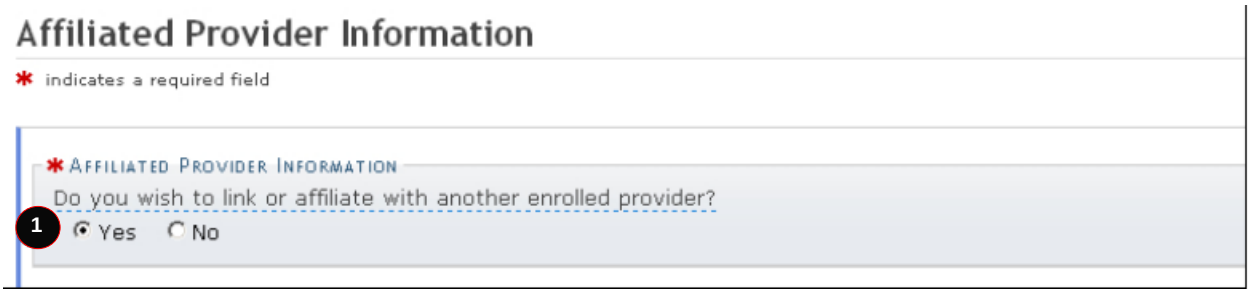
Exhibit 15. HSO Services Page

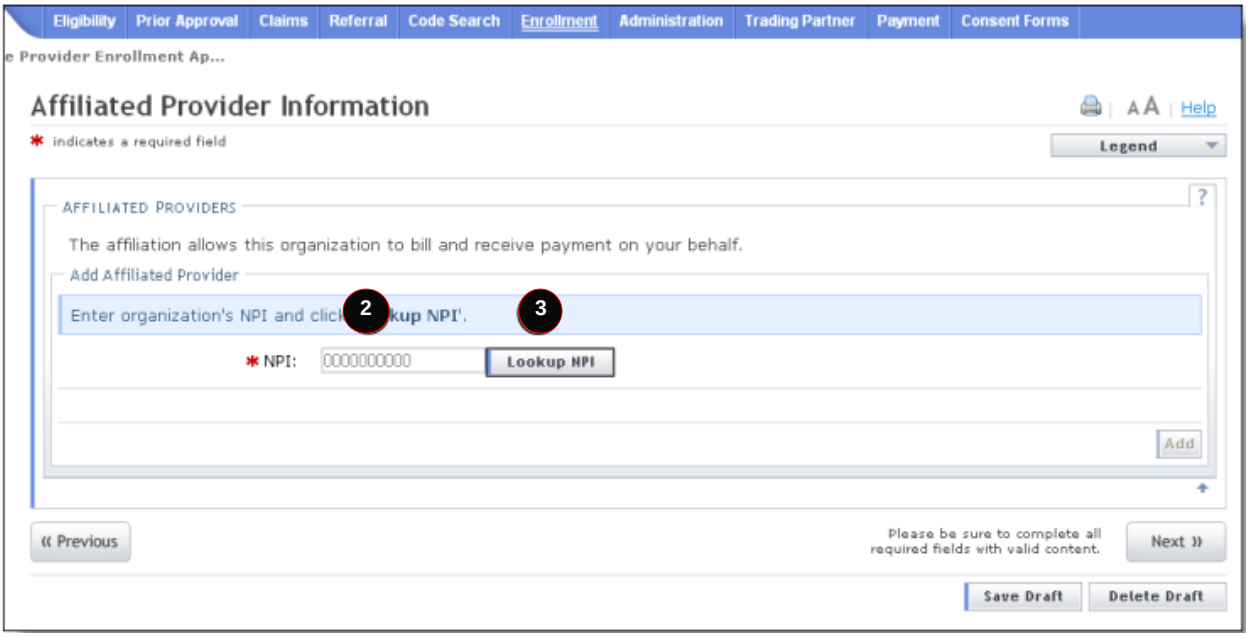
Step	Action
1	Add **Service Location**: Select the radio button beside each service location.
2	Select the **Edit Location** button.
3	Select one or more of the following services provided at each location: **Housing**, **Interpersonal Safety or Toxic Stress**, **Cross Domain, Food and Nutrition**, **Transportation**.

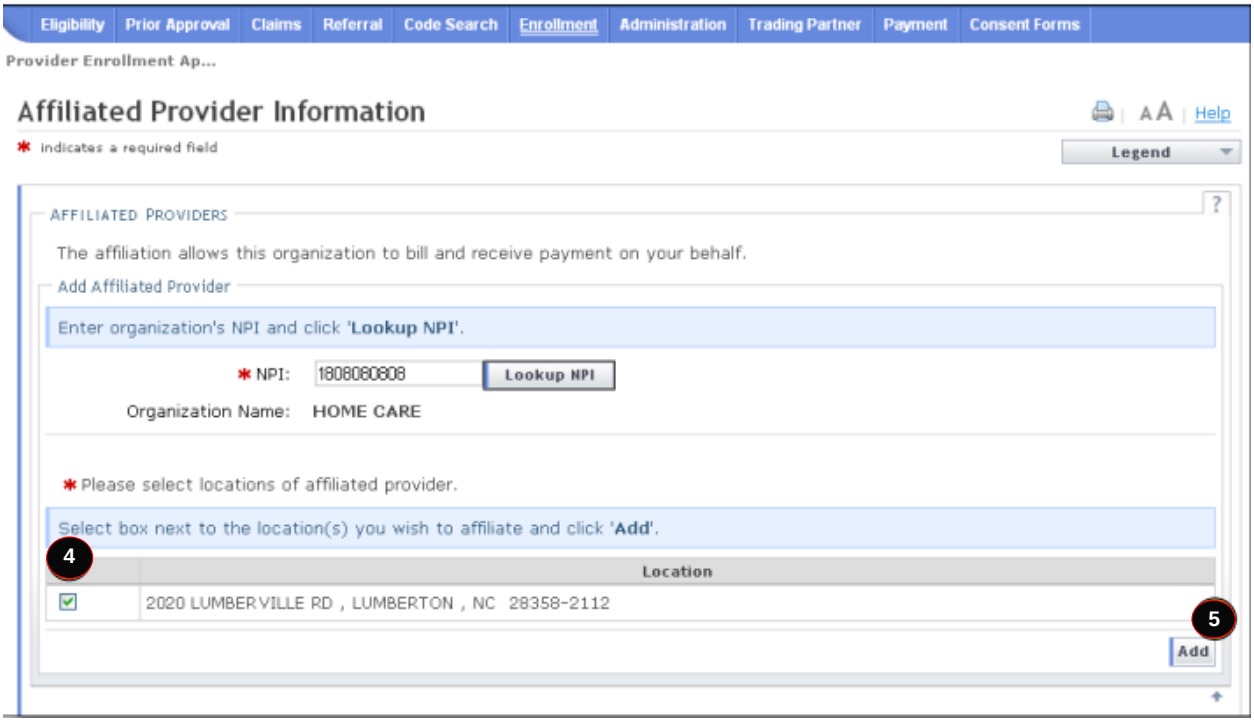
Step	Action
4	Select **Save Location**.
5	Select **Next**.

3.11 PROVIDER AFFILIATION PAGE

The Affiliated Provider Information screen displays.







Step	Action
1	The **Affiliated Provider Information** screen displays. To display the search option, click the **Yes** radio option, illustrated below.
2	Once you display the **Affiliated Provider Information** page, enter the Group/Organization NPI in the search field.
3	Select the **Lookup NPI** button.
4	The search results will display. Click the checkbox next to the appropriate provider location(s).
5	Select the **Add** button in the bottom-right corner of the window.

3.12 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.

Note: If you are enrolling with only an HSO taxonomy code, there is no required accreditation, certification, or license.

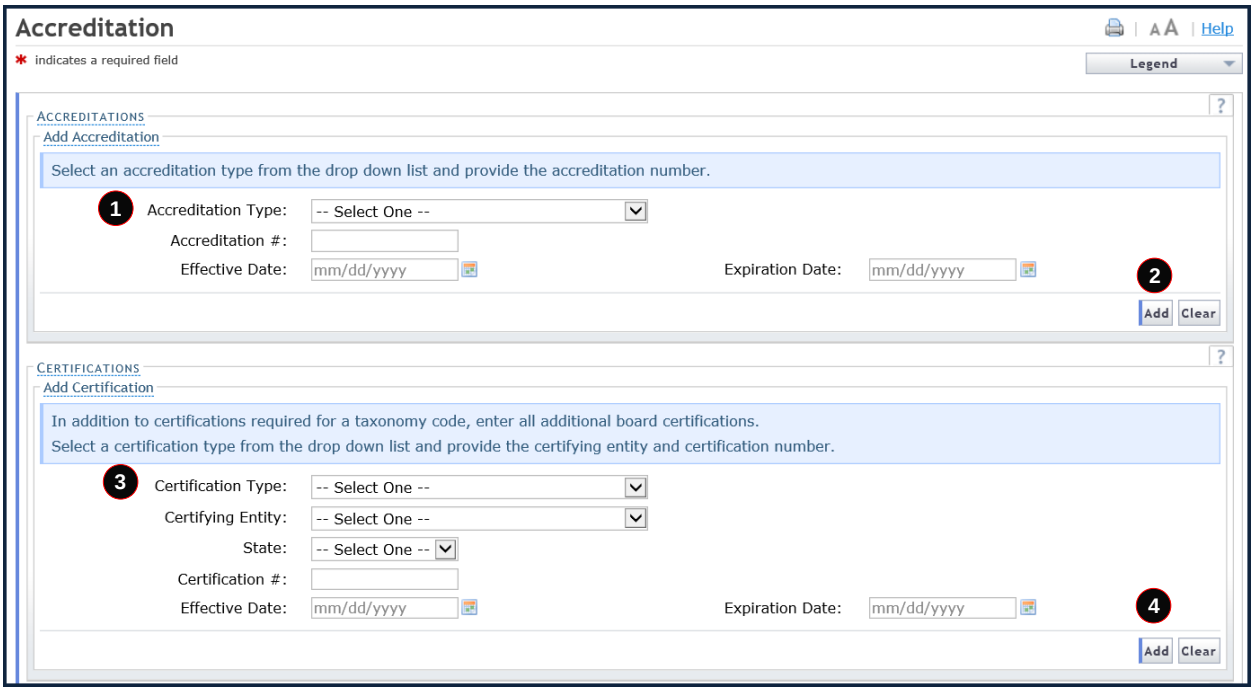


Exhibit 16. Accreditation Page #1

Step	Action
1	Add Accreditation: Enter **Accreditation Type**, **Accreditation #**, **Effective Date**, and **Expiration Date**. If your accreditation does not have an expiration date, leave this field blank.
2	Add Certification: Enter **State**, **Certification #**, **Effective Date**, and **Expiration Date**. If your certification does not have an expiration date, leave this field blank.

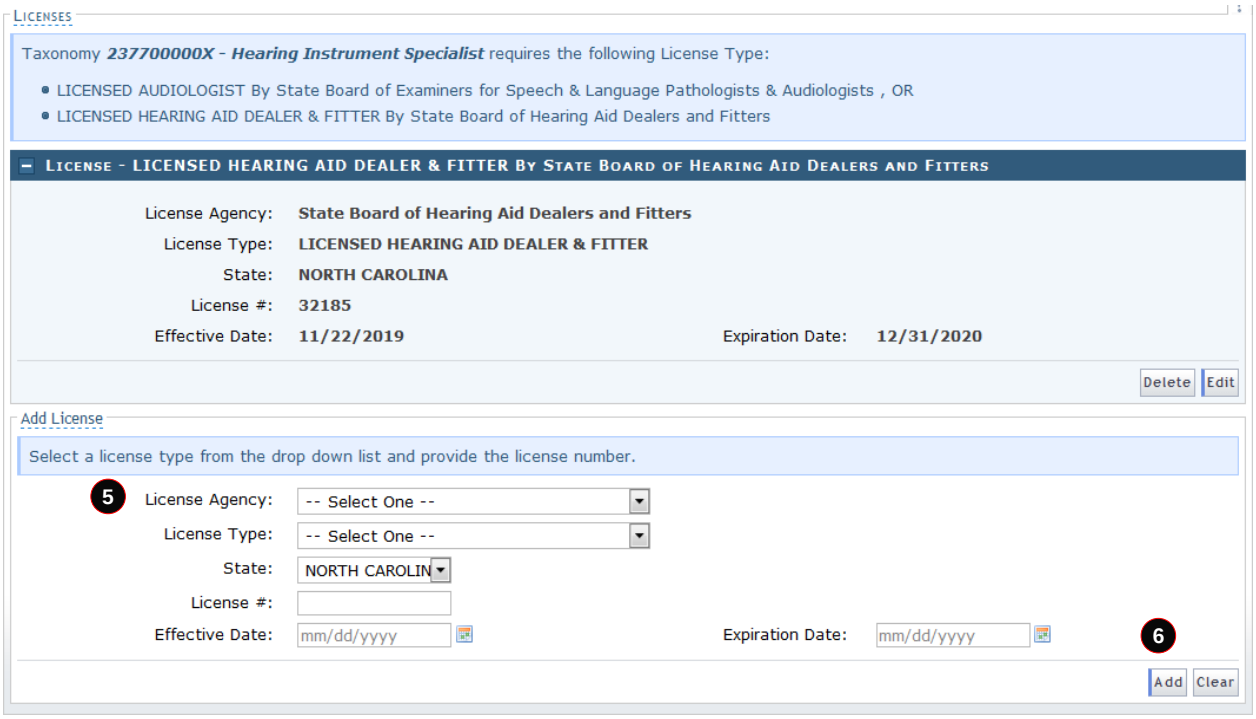


Exhibit 17. Accreditation Page #2

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.

3.13 HOURS PAGE

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

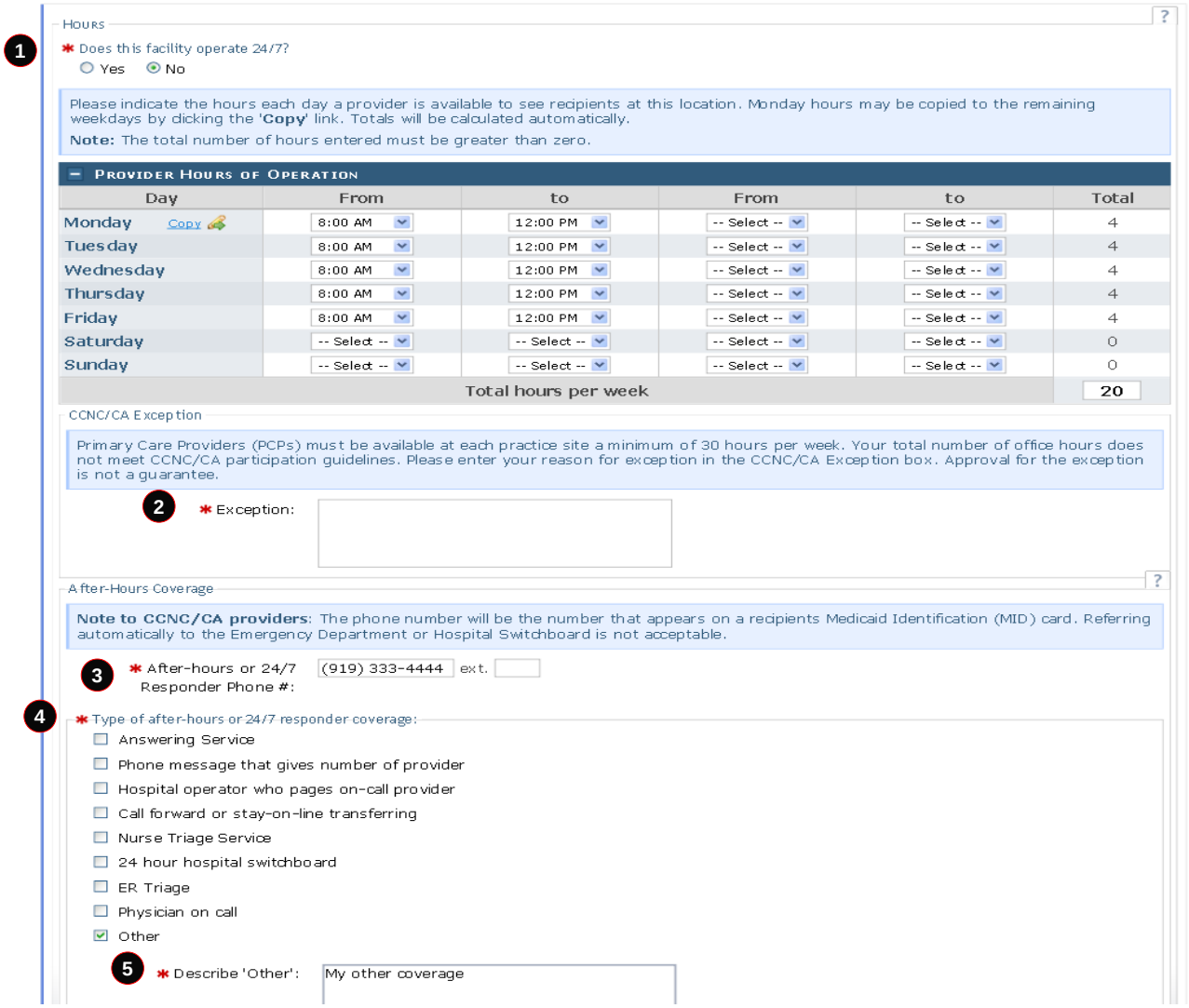


Exhibit 18. Hours Page

Step	Action
1	Click the appropriate radio button beside **Does this Facility operate 24/7?** If **No** is selected, enter the hours of operation, if applicable.
2	If the provider operates for less than a minimum of 30 hours per week, enter an explanation in the **Exception** box.
3	Enter the appropriate phone number in the **After-hours or 24/7 Responder Phone** # box.
4	Indicate the type of after-hours or 24/7 responder coverage.
5	If Other is selected as the type of after-hours or 24/7 responder coverage, enter a description in the **Describe 'Other'** box.

3.14 SERVICES PAGE

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

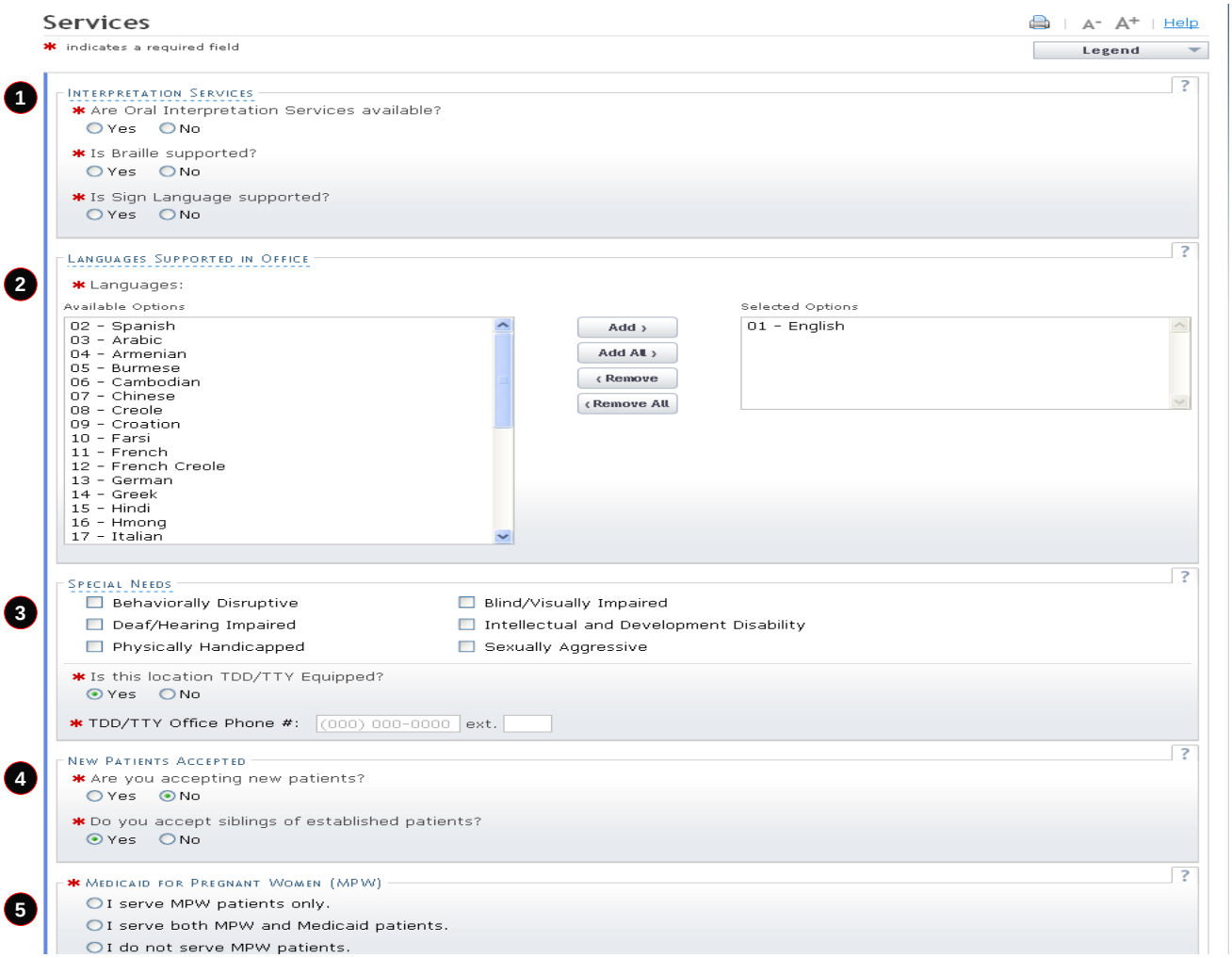


Exhibit 19. Services Page

Step	Action
1	Select the appropriate radio buttons beside **Are Oral Interpretation Services Available**, **Is Braille Supported** and **Is Sign Language Supported**.
2	Indicate the languages supported in office. Highlight the supported language and select the **Add** button to add it to the **Selected Options** box.
3	Select the check box next to the **Special Needs** services offered, if applicable.
4	Select the appropriate radio buttons in the **New Patients Accepted** section.
5	Indicate the appropriate choice in the **Medicaid for Pregnant Women** section. **Note**: HSOs would select option 2 "I serve both MPW and Medicaid patients."

3.15 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).

Note: Agents and managing employees list should only include HSO staff working on the Pilots.

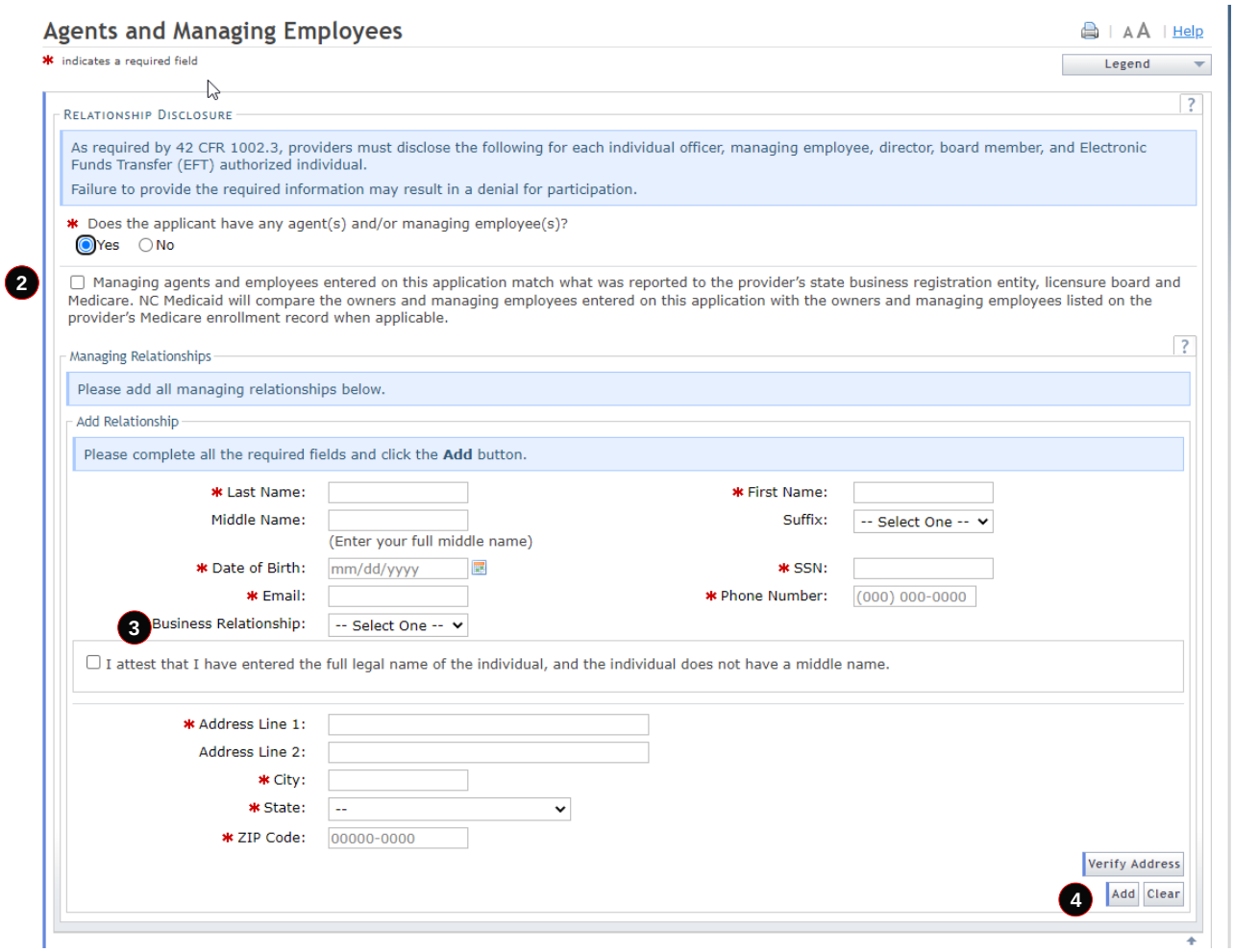


Exhibit 20. Agents and Managing Employees Page

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	Select the attestation box. Managing agents and employees entered on this application must match what was reported to the provider's state business registration entity, licensure board and Medicare. NC Medicaid will compare the owners and managing employees entered on this application with the owners and managing employees listed on the provider's Medicare enrollment record when applicable.
3	In the **Add Relationship** section: • 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 checkbox: I attest that I have entered the full legal name of the individual, and the individual does not have a middle name. • Select **Verify address**.
4	Select the **Add** button to continue.

3.16 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.

HSO-only providers will not be submitting claims directly to NCTracks. However, as a default selection, please select the first option '**Submit a single claim via the NCTracks Provider Portal**'.

If the individual selected YES to the rendering/attending only question on the Individual Basic Info Page, this page will not display.

Note: For more information on the Abbreviated MCR options, refer 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.

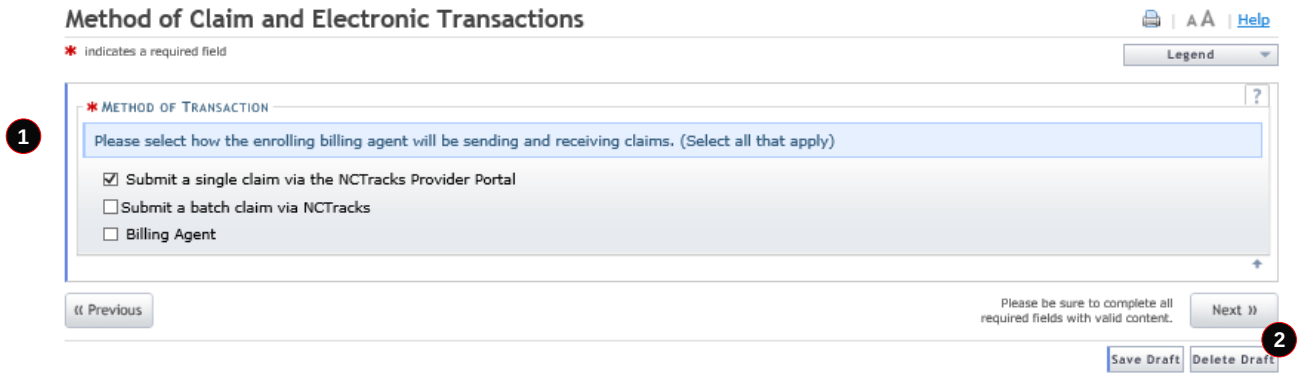


Exhibit 21. Method of Claim and Electronic Transactions

Step	Action
1	Select the appropriate check box(es) in the **Method of Transaction** section.
2	Select the **Next** button.

3.17 EFT ACCOUNT INFORMATION PAGE

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

Note: Atypical individual providers will be rendering/attending only providers and we will not be collecting EFT Account Information. If an individual selected YES to the rendering/attending only question on the Individual Basic Info Page, this page will not display.

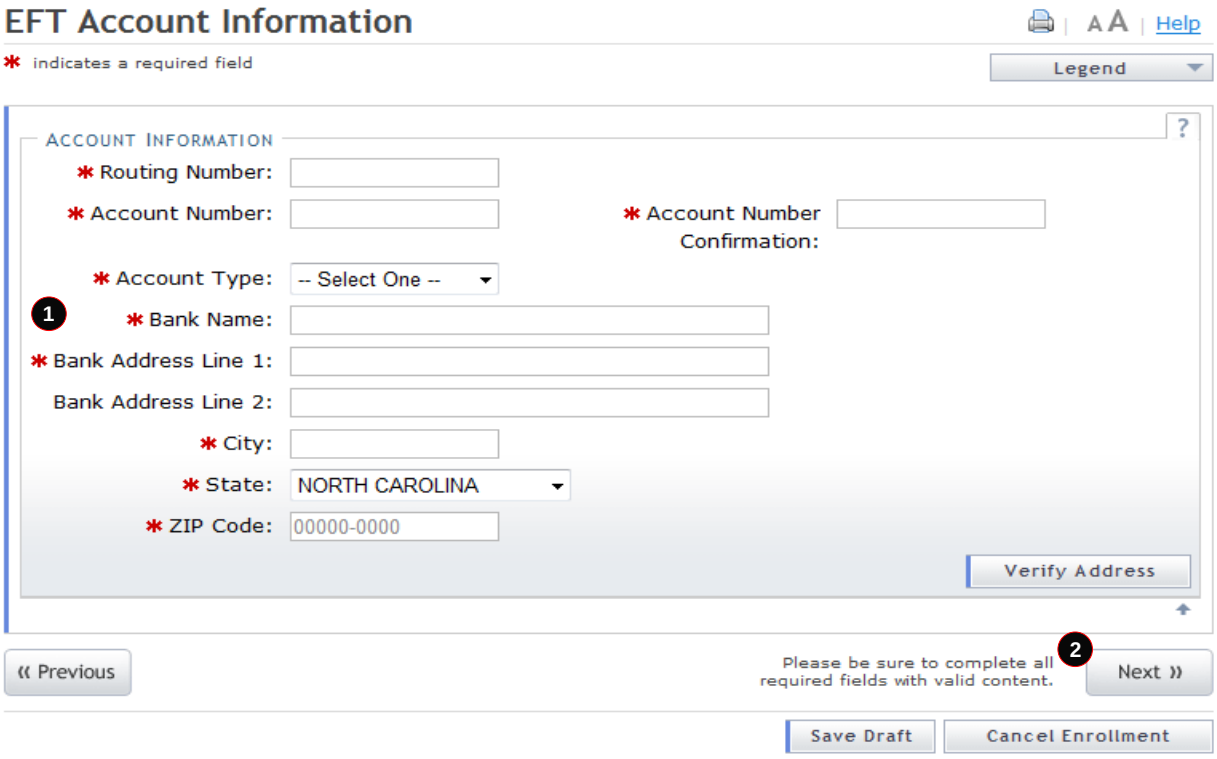


Exhibit 22. EFT Account Information Page

Step	Action
1	Enter the account information.
2	Select the **Next** button.
	Note: Atypical individual providers will be rendering/attending only providers and we will not be collecting EFT Account Information. If an individual selected **YES** to the rendering/attending only question on the Individual Basic Info Page, this page will not display.

3.18 EXCLUSION SANCTION INFORMATION PAGE

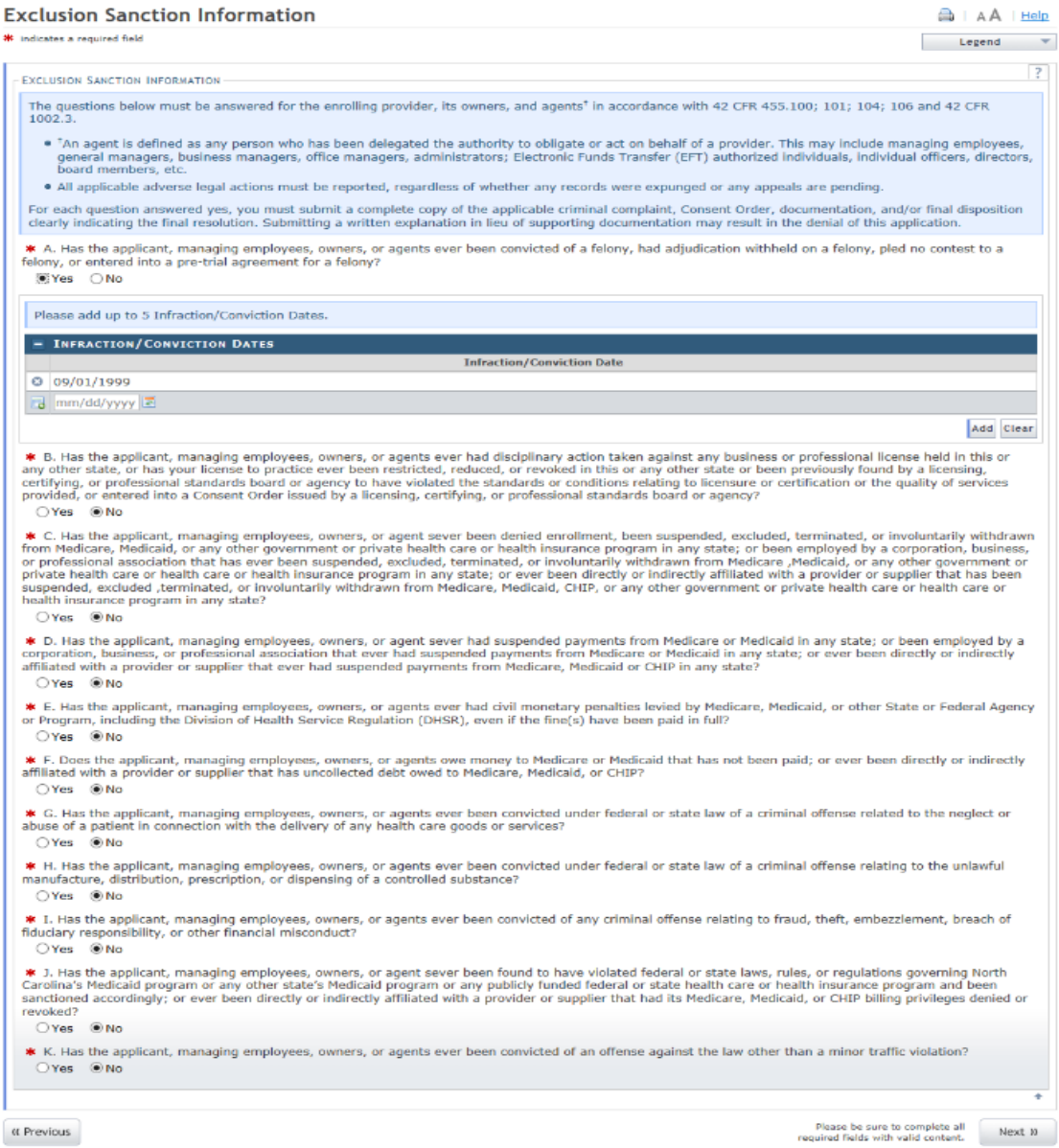


Exhibit 23. Exclusion Sanction Information Page

Step	Action
1	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. 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.

Step	Action
	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). **Note**: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

3.19 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.

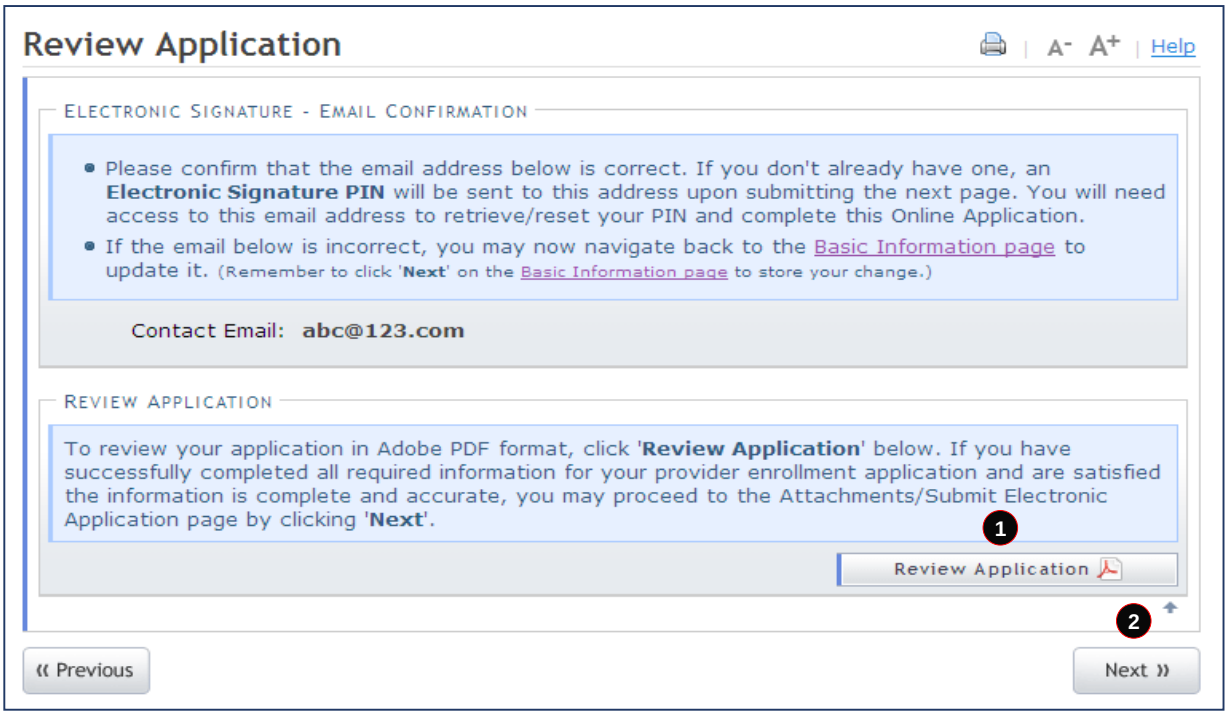


Exhibit 24. Review Application Page

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

3.20 APPLICATION SAVED PAGE

This page displays when the application is saved.

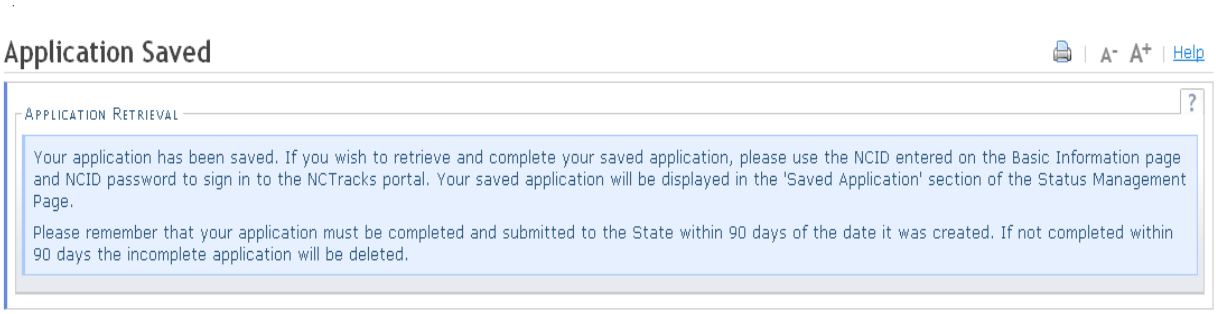


Exhibit 10. Application Saved Page

3.21 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.

HSOs will have the opportunity to use capacity-building funds to cover the application fee.

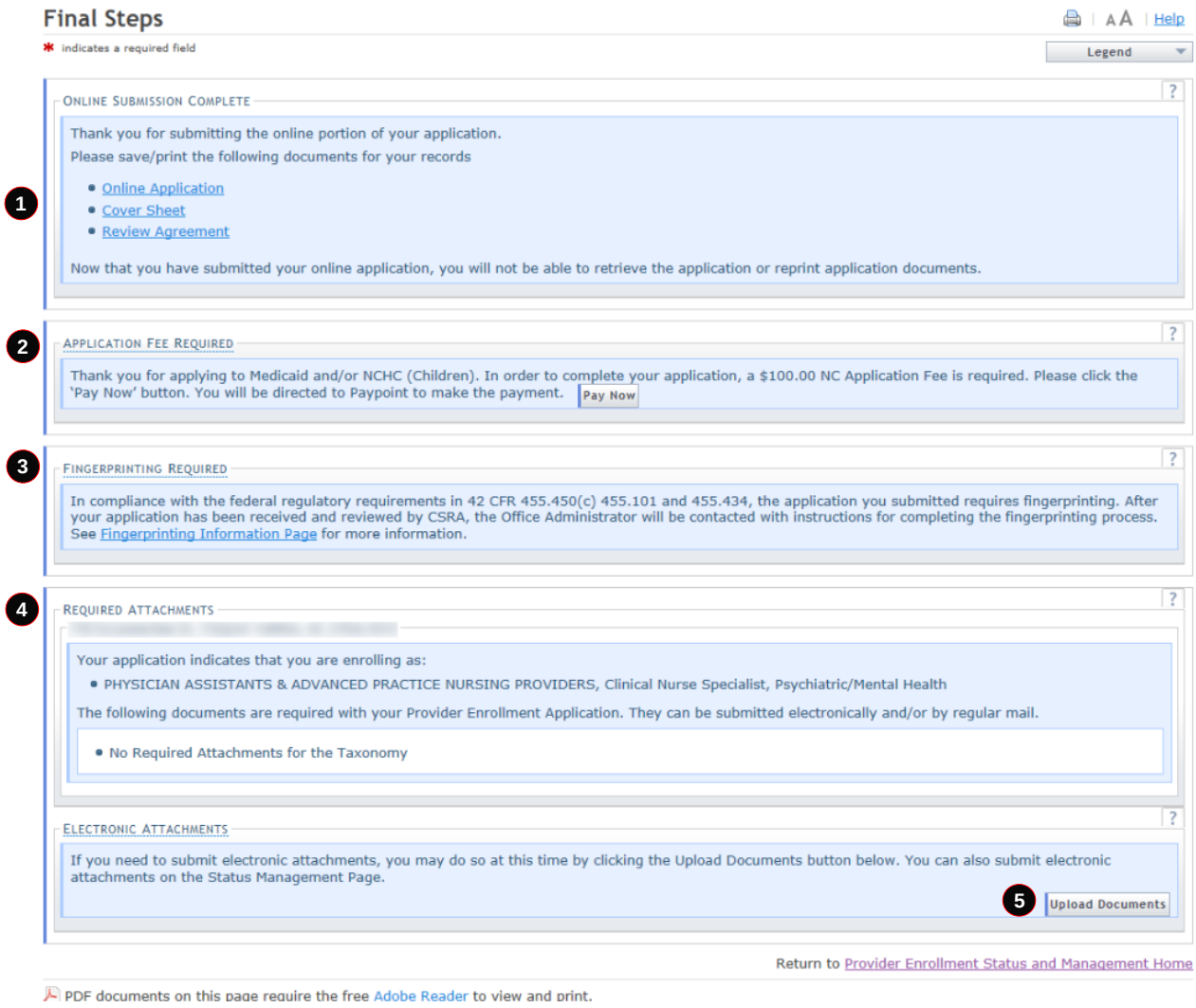


Exhibit 26. Final Steps Page

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 and/or NCHC.
3	Fingerprinting Required: This section will display if the application requires fingerprinting. Not applicable to HSO-only providers
4	Required Attachments: Review the list of documents that need to be included with the application.
5	Select the **Upload Documents** button if any electronic attachments need to be submitted.

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4.0 Re-verification

Most providers are required to provide a Re-verification application every five years; however, providers with HSO-only taxonomy codes are exempt from Re-verification.

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5.0 Maintain Eligibility

If providers have not had any claim activity within the last 12 months, providers are required to complete a Maintain Eligibility application if they intend to stay active. The Notification of Inactivity Letter is sent to the provider's Message Center inbox if the provider has not had any claim activity within the last 12 months. If the application is not submitted, the provider will be terminated. A Termination Letter will be mailed to the provider. The provider will be required to re-enroll if they wish to participate.

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