

# NCMMIS Human Service Organization Enrollment Participant User Guide

**PREPARED FOR:**

North Carolina Department of  
Health and Human Services

DHHS MES VMU

**TRACKING NUMBER:**

PUG\_HSO002  
Version V2.0  
**FINAL**

**SUBMITTED BY:**

CSRA



NC DEPARTMENT OF  
HEALTH AND  
HUMAN SERVICES

October 27, 2022

**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
V1.1	September 16, 2022	Final version
D1.1.1	September 12, 2022	Updated.
V1.0	November 30, 2021	Final version
D1.0.1	November 22, 2021	Initial submission

## Table of Contents

<b>1.0 Welcome</b>	<b>1</b>
1.1 Course Overview	1
1.2 Course Benefits	1
1.3 Course Objectives	1
1.4 Prerequisites	1
<b>2.0 Human Services Organization Applications</b>	<b>3</b>
2.1 Introduction	3
2.2 Objectives	3
2.3 Help System	3
<b>3.0 Initial Enrollment</b>	<b>5</b>
3.1 Navigating to Provider Applications – Initial Enrollment	5
3.2 Online Provider Enrollment Application Page	8
3.3 Organization Basic Information Page	10
3.4 Terms and Conditions Page	12
3.5 Basic Information Completed Page	13
3.6 Health / Benefit Plan Selection Page	13
3.7 Ownership Information Page	14
3.8 Addresses Page	16
3.9 Taxonomy Classification Page	18
3.10 HSO Services Page	19
3.11 Provider Affiliation Page	20
3.12 Accreditation Page	21
3.13 Hours Page	24
3.14 Services Page	25
3.15 Agents and Managing Employees Page	26
3.16 Method of Claim and Electronic Transactions Page	28
3.17 EFT Account Information Page	29
3.18 Exclusion Sanction Information Page	30
3.19 Review Application Page	31
3.20 Application Saved Page	31
3.21 Final Steps Page	32
<b>4.0 Re-verification</b>	<b>35</b>
<b>5.0 Maintain Eligibility</b>	<b>37</b>

## List of Exhibits

Exhibit 1. NCTracks Home Page .....	5
Exhibit 2. Public Providers Page .....	6
Exhibit 3. Getting Started Page .....	7
Exhibit 4. NCTracks Login Page .....	7
Exhibit 5. Online Provider Enrollment Application Page .....	9
Exhibit 6. Organization Basic Information Page .....	10
Exhibit 7. Terms and Conditions Page .....	12
Exhibit 8. Basic Information Completed Page .....	13
Exhibit 9. Health / Benefit Plan Selection Page .....	14
Exhibit 10. Ownership Information Page .....	15
Exhibit 11. Addresses Page #1 .....	16
Exhibit 12. Addresses Page #2 .....	16
Exhibit 13. Addresses Page #3 .....	17
Exhibit 14. Taxonomy Classification Page .....	18
Exhibit 15. HSO Services Page .....	19
Exhibit 16. Accreditation Page #1 .....	22
Exhibit 17. Accreditation Page #2 .....	23
Exhibit 18. Hours Page .....	24
Exhibit 19. Services Page .....	25
Exhibit 20. Agents and Managing Employees Page .....	26
Exhibit 21. Method of Claim and Electronic Transactions .....	28
Exhibit 22. EFT Account Information Page .....	29
Exhibit 23. Exclusion Sanction Information Page .....	30
Exhibit 24. Review Application Page .....	31
Exhibit 25. Application Saved Page .....	32
Exhibit 26. Final Steps Page .....	33

## 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:

[illegible]

**This Page Intentionally Left Blank**

## 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

**This Page Intentionally Left Blank**



## 3.0 Initial Enrollment

### 3.1 NAVIGATING TO PROVIDER APPLICATIONS – INITIAL ENROLLMENT

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

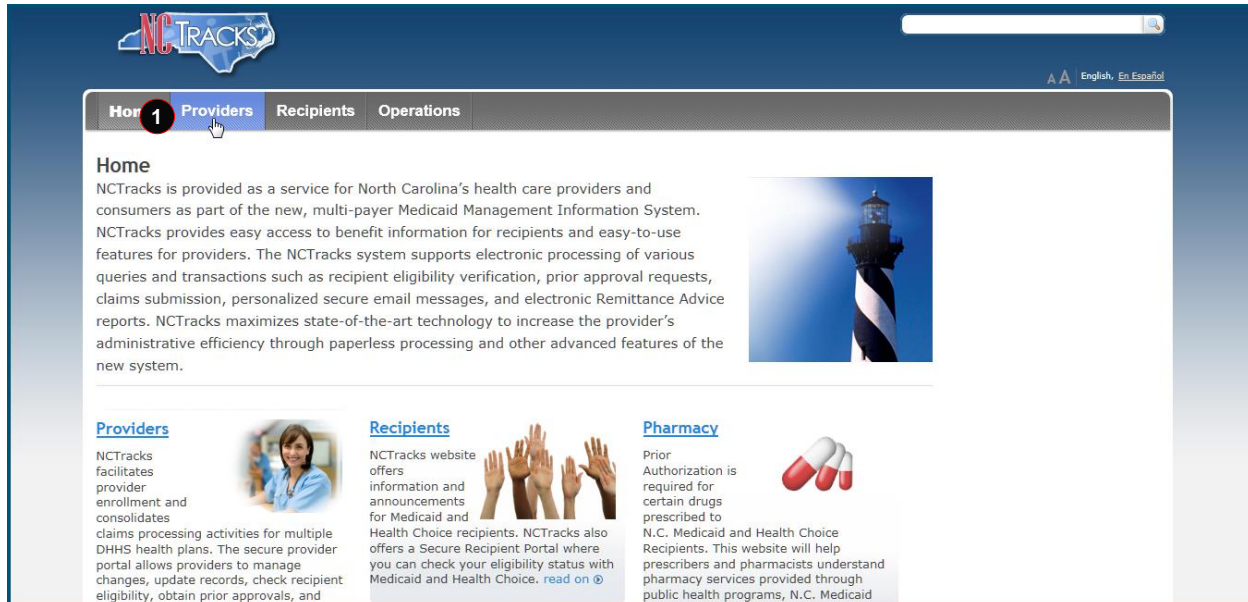


Exhibit 1. NCTracks Home Page

Step	Action
1	Select the <b>Providers</b> link. The public <b>Providers</b> 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

**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

## 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](mailto: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 <b>Provider Enrollment</b> ; menu options display.
2	Select the <b>Getting Started With Enrollment</b> menu option. The <b>Getting Started</b> page displays.

### Exhibit 3. Getting Started Page

### Exhibit 4. NCTracks Login Page

Page 7 of 38

Step	Action
Note	<p>Select the <b>NCID</b> link only if provider (the OA) does not have an NCID.</p> <p>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</p> <ul style="list-style-type: none"> <li>• Desired username</li> <li>• First Name</li> <li>• Last Name</li> <li>• Email Address</li> <li>• Mobile Number (Not Required but recommended)</li> <li>• New password <ul style="list-style-type: none"> <li>– Password is case sensitive.</li> <li>– Must be at least 8 characters long.</li> <li>– Must not include part of your name or user name.</li> <li>– Must not include a common word or commonly used sequence of characters.</li> <li>– Can be changed no more often than once every 3 days.</li> <li>– Must have at least 3 of the 5 character types below: <ul style="list-style-type: none"> <li>• Uppercase (A-Z)</li> <li>• Lowercase (a-z)</li> <li>• Number (0-9)</li> <li>• Symbol (!, #, \$, etc.)</li> <li>• Other language characters not listed above</li> </ul> </li> </ul> </li> <li>• New password may not have been used previously.</li> </ul> <p>Click <b>Continue</b>.</p>
Note	<p>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 <i>Provider Multi-Factor Authentication Registration Process</i> job aid located in SkillPort.</p>

### 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

Page 9 of 38

### 3.3 ORGANIZATION BASIC INFORMATION PAGE

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

**Organization Basic Information**

\* indicates a required field

Legend

1 IDENTIFYING INFORMATION

\* Organization Name:

\* EIN:

\* NPI:

\* Email:

\* Month of Fiscal Year End: -- Select One --

2 DOING BUSINESS AS (DBA)

\* Do you operate under a trade or company name?

☐ Yes ☐ No

3 OWNERSHIP INFORMATION

\* Business Type: CORPORATION

☒ The Business Type entered on this application matches what was reported to the provider's state business registration entity.

REGISTERING WITH NC SECRETARY OF STATE

\* Are you required by law to register with NC Secretary of State?

☐ Yes ☒ No

4 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)

\* Contact Email:

SSN: \*\*\*-\*\*-9855

\* Office Phone #:  t.

Office Fax #:

\* Is this contact person an Owner or Managing Employee?

☒ Owner ☐ Managing Employee

5 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:

☐ 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 6. Organization Basic Information Page



Step	Action
1	Identifying Information: Enter <b>Organization Name, EIN, NPI, Email, and Month of Fiscal Year End.</b>
2	<p>Doing Business As (DBA): Answer <b>Yes</b> or <b>No</b> to the question: “<b>Do you operate under a trade or company name?</b>”.</p> <ul style="list-style-type: none"> <li>If you answer <b>Yes</b>, the field will expand, prompting you to enter the <b>DBA Name</b> and <b>Years Doing Business Under This Name</b>.</li> <li><b>Note:</b> The DBA Name must be registered in the county where the service is being provided.</li> <li>If you answer <b>No</b>, you may continue to the next required field on the page.</li> </ul>
3	<p>Ownership Information: Select the <b>Business Type</b> from the drop-down menu:</p> <ul style="list-style-type: none"> <li><b>City/Municipality:</b> Select this if the Organization is owned by a City or a Municipality.</li> <li><b>Corporation:</b> 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.</li> <li><b>Federal:</b> Select this if ownership falls within the jurisdiction of the federal government.</li> <li><b>Indian Health Services:</b> Select this if the ownership falls within the jurisdiction of the Indian Health Services.</li> <li><b>Limited Liability Corporation:</b> Select this (filing status) if this is a Limited Liability Corporation (LLC).</li> <li><b>Local Government Agency:</b> Select this if the Organization is owned by a City or a Municipality.</li> <li><b>Non-Profit:</b> Select this if it is a non-profit enterprise.</li> <li><b>Partnership:</b> Select this if it is a General Partnership, or a Limited Partnership, where two or more people have created this business entity.</li> <li><b>State:</b> Select this if the entity is owned by the state in which it operates.</li> <li><b>Ownership Information:</b> 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.</li> </ul>
Note	<p>The <b>Organization Name</b> and <b>DBA Name</b> fields only allow the following characters:</p> <ul style="list-style-type: none"> <li>Alpha (A – Z)</li> <li>Numeric (0 – 9)</li> <li>Hyphen (-)</li> <li>Ampersand (&amp;)</li> </ul> <p>If <b>Yes</b> is selected for the question ‘<b>Will your income be reported to an EIN?</b>’, enter <b>DBA Name</b> and <b>Years Doing Business Under This Name</b>.</p> <p>The <b>DBA Name</b> field only allows the following characters:</p> <ul style="list-style-type: none"> <li>Alpha (A – Z)</li> <li>Numeric (0 – 9)</li> <li>Hyphen (-)</li> <li>Ampersand (&amp;)</li> </ul>
4	Office Administrator (Authorized Individual): Enter <b>Last Name, First Name, Contact Email, Office Phone #, and User ID (NCID).</b>
5	Effective Date Requested: Enter earliest HSO-NL contract Effective Date.
6	Check box beside Attestation: <b>I attest that the requested effective date is correct and understand that it cannot be changed once the application is submitted.</b>
7	Select <b>Next</b> .

### 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<sup>-</sup> A<sup>+</sup> | [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.

#### Basic Information Completed

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

\* indicates a required field

ELECTRONIC SIGNATURE ?

Your **Electronic Signature PIN** will be sent to the email address provided on the Basic Information page. You will need this PIN to electronically sign this enrollment application upon submission. Your PIN will also be used to electronically sign future secure submissions.

[Or]

Our records indicate that an **Electronic Signature PIN** has already been associated with this Office Administrator's NCID. Please use the current PIN to electronically sign this application upon submission. If you have lost or forgotten your PIN, you will have the opportunity to reset it upon submission.

APPLICATION RETRIEVAL ?

You have successfully completed the basic information portion of the enrollment application.

If you wish to retrieve and complete your saved application, use the Status Management link from the [Provider Enrollment Home](#). You'll need your NCID and password to sign into the NCTracks portal. Please complete this application within 90 days for submission to the state. If it is not completed within 90 days, the incomplete application will be deleted.

« Previous

Next »

Application Last Updated: 2009-11-22

Save Draft

Cancel Enrollment

#### 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.

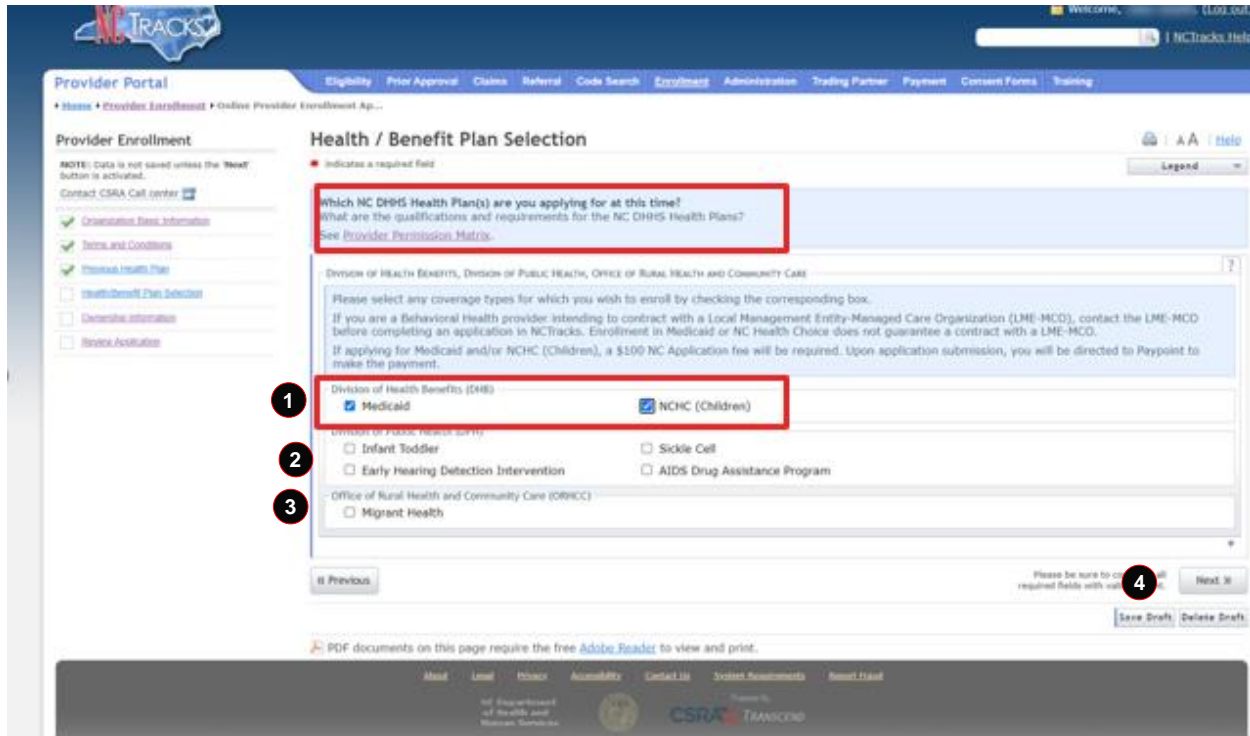


Exhibit 9. Health / Benefit Plan Selection Page

Step	Action
1	This section includes Division of Health Benefits (DHB): <b>Medicaid</b> and <b>NCHC (Children)</b> . Do not opt out of coverage under DHB.
2	Opt out of any coverage by deselecting the appropriate checkbox: Division of Public Health (DPH): <b>Infant Toddler</b> , <b>Sickle Cell</b> , <b>Early Hearing Detection Intervention</b> , and <b>AIDS Drug Assistance Program</b> .
3	Opt out of any coverage by deselecting the appropriate checkbox: Office of Rural Health and Community Care (ORHCC): <b>Migrant Health</b> .
4	Select the <b>Next</b> button to continue.
Note	If a provider is enrolling as an OPR Lite and/or OOS provider, they will only see DHB health plans: <b>Medicaid</b> and <b>NCHC (Children)</b> .

### 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.

## Ownership Information

\* indicates a required field

Legend

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

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

2 Last Name : smith First Name : michael  
Middle Name : w Suffix: -- Select One --  
\* Date of Birth: mm/dd/yyyy SSN: \*\*\*-\*\*-9855  
\* Gender: -- Select One --  
\* Email: MICHELLE.STCLAIR \* Phone Number: (919) 096-7544  
\* Address Line 1:  
Address Line 2:  
\* City:  
\* State: --  
\* ZIP Code: 00000-0000  
3 Verify Address  
\* Relationship to Another Disclosing Person: -- Select One -- \* Percent of Ownership/Control Interest: %  
Save

### 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

Previous

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

Next

Save Draft Delete Draft

## 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 <b>Yes</b> or <b>No</b> and the attestation box. <i>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.</i>
2	Select the <b>Edit</b> button to edit an existing Shareholder/Partner to change <b>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.</b>
3	Then select the <b>Verify Address</b> button and then <b>Save</b> button.
4	Add Shareholder/Partner: <ul style="list-style-type: none"> <li>For Individual, enter <b>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.</b> Then select the <b>Add</b> button.</li> <li>For Business, enter <b>Business Legal Name, EIN, Address, City, State, ZIP Code, Percent of Ownership/Control Interest, and Begin Date.</b> Then select the <b>Add</b> button.</li> </ul>
5	Select the <b>Next</b> 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 <b>Office Phone #</b> , <b>Office Fax #</b> , <b>Address</b> , <b>City</b> , and <b>State</b> . Select the <b>Verify Address</b> 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 <b>Yes</b> or <b>No</b> .

Step	Action
	<b>Note:</b> 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 <b>Yes</b> or <b>No</b> . If <b>Yes</b> , enter <b>Office Phone #</b> , <b>Address</b> , <b>City</b> , <b>State</b> , and <b>ZIP Code</b> .
5	Select the <b>Add</b> button to add the service location.
6	Select the <b>Next</b> 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.

**Taxonomy Classification** Legend

\* indicates a required field

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 (NPPES) when you enumerated this NPI.  
If a submitted taxonomy has not been reported to NPPES, please report it within the next 30 days.

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.

Add Taxonomy Classification

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

1 \* Provider Type: OTHER SERVICE PROVIDERS

\* Classification: Prevention Professional

\* Area of Specialization: None

2 **Add** **Clear**

**Taxonomy Classification** Legend

\* indicates a required field

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 (NPPES) when you enumerated this NPI.  
If a submitted taxonomy has not been reported to NPPES, please report it within the next 30 days.

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.

Add Taxonomy Classification

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

\* Provider Type: AGENCIES

\* Classification: Public Health or Welfare

\* Area of Specialization: None

**Add** **Clear**

**Exhibit 14. Taxonomy Classification Page**



Step	Action
1	<p>Add Taxonomy Classification: Using the drop-down menus, select <b>Provider Type</b>, <b>Classification</b>, and <b>Area of Specialization</b> (if applicable).</p> <p>If you are enrolling as an individual or atypical individual provider, select the following:</p> <ul style="list-style-type: none"> <li>• <b>Provider Type:</b> Other Service Providers</li> <li>• <b>Classification:</b> Prevention Professional</li> <li>• <b>Area of Specialization:</b> None</li> </ul> <p>If you are enrolling as an organization or an atypical organization, select the following:</p> <ul style="list-style-type: none"> <li>• <b>Provider Type:</b> Agencies</li> <li>• <b>Classification:</b> Public Health or Welfare</li> <li>• <b>Area of Specialization:</b> None</li> </ul>
2	<p>Select the <b>Add</b> button to add another Taxonomy Classification.</p> <p><b>Note:</b> Repeat this process to add multiple taxonomy codes. You can enter up to 15 taxonomy codes.</p>

### 3.10 HSO SERVICES PAGE

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

The screenshot shows the 'Health Service Organization (HSO) Services' page. On the left is a 'Provider Enrollment' sidebar with various links. The main area has a 'SERVICE LOCATIONS' table with columns 'Select', 'Location', and 'Form Status'. Below this is a section for 'HEALTH SERVICE ORGANIZATION (HSO) SERVICES' with a list of services to select. Numbered callouts indicate the following steps: 1. Selecting a service location from the table. 2. Clicking the 'Edit Location' button. 3. Selecting HSO services from a list. 4. Clicking the 'Save Location' button. 5. Clicking the 'Next' button.

Exhibit 15. HSO Services Page

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

Step	Action
4	Select <b>Save Location</b> .
5	Select <b>Next</b> .

### 3.11 PROVIDER AFFILIATION PAGE

The Affiliated Provider Information screen displays.

## Affiliated Provider Information

\* indicates a required field

\* AFFILIATED PROVIDER INFORMATION

Do you wish to link or affiliate with another enrolled provider?

1 ☒ Yes ☐ No

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

e Provider Enrollment Ap...

## Affiliated Provider Information

\* indicates a required field

Legend

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**.

2 3

\* NPI:

« Previous

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

Next »



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

Provider Enrollment Ap...

### Affiliated Provider Information

\* Indicates a required field

Legend

**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: 1808080808 **Lookup NPI**

Organization Name: HOME CARE

\* Please select locations of affiliated provider.

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

	Location
<input checked="" type="checkbox"/>	2020 LUMBERVILLE RD , LUMBERTON , NC 28358-2112

**4** **5**

**Add**

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

### Accreditation

\* indicates a required field

Legend

#### ACCREDITATIONS

Add Accreditation

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

1

Accreditation Type: -- Select One --

Accreditation #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

2

Add Clear

#### CERTIFICATIONS

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.

3

Certification Type: -- Select One --

Certifying Entity: -- Select One --

State: -- Select One --

Certification #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

4

Add Clear

**Exhibit 16. Accreditation Page #1**

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

**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 17. Accreditation Page #2**

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

Hours

1

Does this facility operate 24/7?

☐ Yes
☒ No

Please indicate the hours each day a provider is available to see recipients at this location. Monday hours may be copied to the remaining weekdays by clicking the 'Copy' link. Totals will be calculated automatically.

Note: The total number of hours entered must be greater than zero.

PROVIDER HOURS OF OPERATION

Day	From	to	From	to	Total
Monday <a href="#">Copy</a>	8:00 AM	12:00 PM	-- Select --	-- Select --	4
Tuesday	8:00 AM	12:00 PM	-- Select --	-- Select --	4
Wednesday	8:00 AM	12:00 PM	-- Select --	-- Select --	4
Thursday	8:00 AM	12:00 PM	-- Select --	-- Select --	4
Friday	8:00 AM	12:00 PM	-- Select --	-- Select --	4
Saturday	-- Select --	-- Select --	-- Select --	-- Select --	0
Sunday	-- Select --	-- Select --	-- Select --	-- Select --	0
Total hours per week					20

CCNC/CA Exception

Primary Care Providers (PCPs) must be available at each practice site a minimum of 30 hours per week. Your total number of office hours does not meet CCNC/CA participation guidelines. Please enter your reason for exception in the CCNC/CA Exception box. Approval for the exception is not a guarantee.

2

Exception:

After-Hours Coverage

Note to CCNC/CA providers: The phone number will be the number that appears on a recipients Medicaid Identification (MID) card. Referring automatically to the Emergency Department or Hospital Switchboard is not acceptable.

3

After-hours or 24/7 Responder Phone #:

(919) 333-4444

ext.

4

Type of after-hours or 24/7 responder coverage:

☐ Answering Service
☐ Phone message that gives number of provider
☐ Hospital operator who pages on-call provider
☐ Call forward or stay-on-line transferring
☐ Nurse Triage Service
☐ 24 hour hospital switchboard
☐ ER Triage
☐ Physician on call
☒ Other

5

Describe 'Other':

My other coverage

Exhibit 18. Hours Page

Step	Action
1	Click the appropriate radio button beside <b>Does this Facility operate 24/7?</b> If <b>No</b> 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 <b>Exception</b> box.
3	Enter the appropriate phone number in the <b>After-hours or 24/7 Responder Phone #</b> box.
4	Indicate the type of after-hours or 24/7 responder coverage.
5	If <b>Other</b> is selected as the type of after-hours or 24/7 responder coverage, enter a description in the <b>Describe 'Other'</b> box.

### 3.14 SERVICES PAGE

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

**Services** Legend

\* indicates a required field

- INTERPRETATION SERVICES**

\* Are Oral Interpretation Services available?  
☐ Yes ☐ No

\* Is Braille supported?  
☐ Yes ☐ No

\* Is Sign Language supported?  
☐ Yes ☐ No
- LANGUAGES SUPPORTED IN OFFICE**

\* Languages:

Available Options

  - 02 - Spanish
  - 03 - Arabic
  - 04 - Armenian
  - 05 - Burmese
  - 06 - Cambodian
  - 07 - Chinese
  - 08 - Creole
  - 09 - Croatian
  - 10 - Farsi
  - 11 - French
  - 12 - French Creole
  - 13 - German
  - 14 - Greek
  - 15 - Hindi
  - 16 - Hmong
  - 17 - Italian

Buttons: Add, Add All, Remove, Remove All

Selected Options

  - 01 - English
- SPECIAL NEEDS**

☐ Behaviorally Disruptive ☐ Blind/Visually Impaired

☐ Deaf/Hearing Impaired ☐ Intellectual and Development Disability

☐ Physically Handicapped ☐ Sexually Aggressive

\* Is this location TDD/TTY Equipped?  
☒ Yes ☐ No

\* TDD/TTY Office Phone #: (000) 000-0000 ext.
- NEW PATIENTS ACCEPTED**

\* Are you accepting new patients?  
☐ Yes ☒ No

\* Do you accept siblings of established patients?  
☒ Yes ☐ No
- \* MEDICAID FOR PREGNANT WOMEN (MPW)**

☐ I serve MPW patients only.

☐ I serve both MPW and Medicaid patients.

☐ I do not serve MPW patients.

**Exhibit 19. Services Page**

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

#### 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.

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

☒ Yes ☐ No

☐ Managing agents and employees entered on this application 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.

##### Managing Relationships

Please add all managing relationships below.

##### Add Relationship

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

\* Last Name:

Middle Name:

(Enter your full middle name)

\* Date of Birth:

\* Email:

3 Business Relationship:

\* First Name:

Suffix:

\* SSN:

\* 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:

Verify Address

4 Add Clear

**Exhibit 20. Agents and Managing Employees Page**

Step	Action
1	Relationship Disclosure: Does the applicant have any agent(s) or managing employee(s)? Select <b>Yes</b> or <b>No</b> ; if <b>Yes</b> , the <b>Managing Relationship</b> 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 <b>Add Relationship</b> section: <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Select <b>Verify address</b>.</li> </ul>
4	Select the <b>Add</b> 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.

#### Method of Claim and Electronic Transactions

\* indicates a required field

Print | A A | Help

Legend

##### \* METHOD OF TRANSACTION

Please select how the enrolling billing agent will be sending and receiving claims. (Select all that apply)

- ☒ Submit a single claim via the NCTracks Provider Portal
- ☐ Submit a batch claim via NCTracks
- ☐ Billing Agent

(( Previous

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

Next ))

Save Draft

Delete Draft

### Exhibit 21. Method of Claim and Electronic Transactions

Step	Action
1	Select the appropriate check box(es) in the <b>Method of Transaction</b> section.
2	Select the <b>Next</b> 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.

#### EFT Account Information

AA | [Help](#)

\* indicates a required field

Legend

ACCOUNT INFORMATION ?

\* Routing Number:

\* Account Number:

\* Account Number Confirmation:

\* Account Type:

-- Select One --

1 \* Bank Name:

\* Bank Address Line 1:

Bank Address Line 2:

\* City:

\* State:

NORTH CAROLINA

\* ZIP Code:

00000-0000

Verify Address

« Previous

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

2 Next »

Save Draft

Cancel Enrollment

#### Exhibit 22. EFT Account Information Page

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

### 3.18 EXCLUSION SANCTION INFORMATION PAGE

**Exclusion Sanction Information**

\* indicates a required field

Legend

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 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. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.

\* 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

Please add up to 5 Infraction/Conviction Dates.

Infraction/Conviction Date
09/01/1999
mm/dd/yyyy

Add Clear

\* 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

Previous Next

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

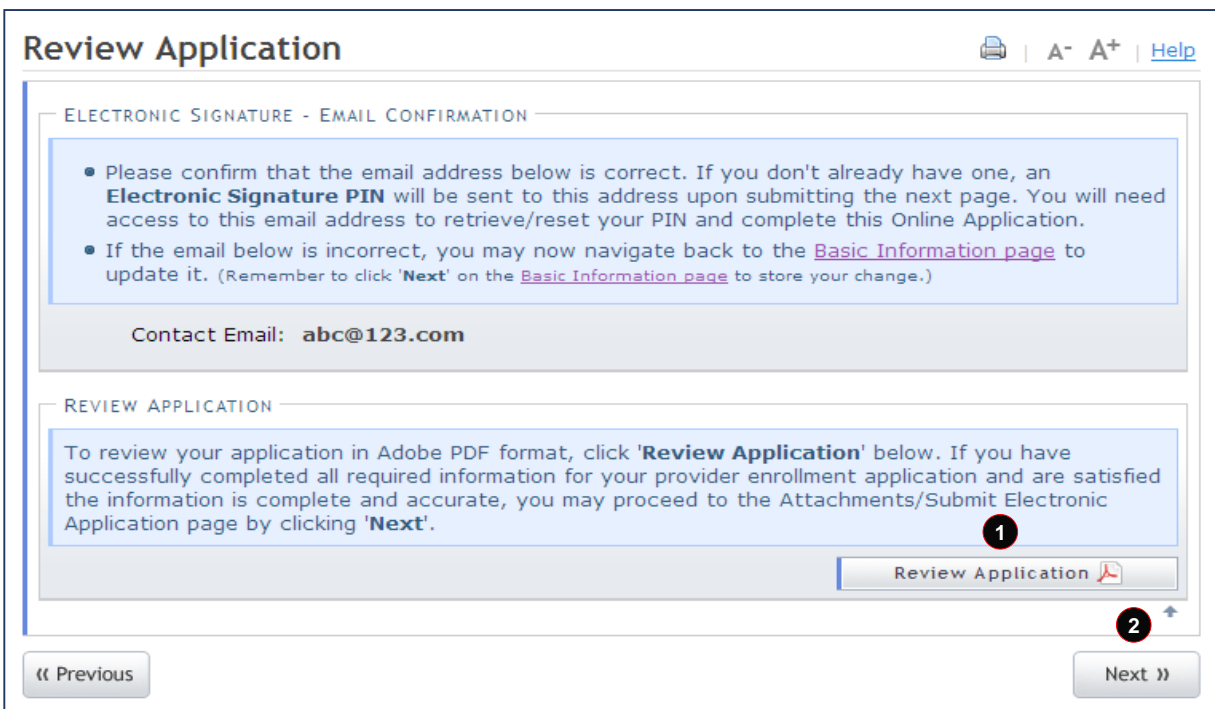
**Exhibit 23. Exclusion Sanction Information Page**

Step	Action
1	<p>Select <b>Yes</b> or <b>No</b> for each Exclusion Sanction question. When <b>Yes</b> is selected for a question, the <b>Infraction/Conviction Dates</b> section displays. Select the <b>Add</b> button to add an Infraction/Conviction Date.</p> <p>For each question answered <b>Yes</b>, 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>

Step	Action
	<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><b>Note:</b> All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p>

### 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 <b>Review Application</b> button.
2	Select the <b>Next</b> button to continue.

### 3.20 APPLICATION SAVED PAGE

This page displays when the application is saved.

## Application Saved

 | A<sup>-</sup> A<sup>+</sup> | [Help](#)

APPLICATION RETRIEVAL 

Your application has been saved. If you wish to retrieve and complete your saved application, please use the NCID entered on the Basic Information page and NCID password to sign in to the NCTracks portal. Your saved application will be displayed in the 'Saved Application' section of the Status Management Page.

Please remember that your application must be completed and 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.

**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.

## 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 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](#)

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

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.

5

[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 26. Final Steps Page

Step	Action
1	Print/save the <b>Online Application</b> and/or <b>Cover Sheet</b> . This will be the only opportunity to save, download, or print the PDFs.
2	Select the <b>Pay Now</b> button. The PayPoint landing page displays. See Addendum B to view the PayPoint process. <b>Note:</b> 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 <b>Upload Documents</b> button if any electronic attachments need to be submitted.

**This Page Intentionally Left Blank**

## 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.

**This Page Intentionally Left Blank**



## 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.

**This Page Intentionally Left Blank**