ADDENDUM AND ATTESTATION REGARDING UNDISCLOSED INFORMATION

NC MEDICAID PROVIDER ENROLLMENT – REVERIFICATION APPLICATIONS ONLY

Provider Name: _____

NC Medicaid Provider NPI/Atypical ID: _____

Reverification Application Reference Number: _____

Purpose

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

This Addendum and Attestation may be submitted only in connection with a pending Reverification Application when credentialing identifies an adverse legal action that was not disclosed on the application's Exclusion/Sanction page.

Provide the following information for each affected person or entity:

Name of Individual or Entity:

_____

Type of Adverse Legal Action (See Sanctions and Exclusions Fact Sheet as needed):

_____

Infraction/Conviction/Legal Action Date:

_____

Explanation, Including the Reason the Information Was Not Previously Disclosed:

_____

_____

_____

_____

_____

_____

Supporting Documentation Attached (e.g. criminal complaint, consent order, court documentation, final disposition):

☐ Yes

☐ No (Offer reason below)

Attestation Statement

I, _____(printed name), acting in my capacity as the authorized Office Administrator for the provider/entity identified above, hereby attest to the undisclosed NC Medicaid Exclusion/Sanction information and any supporting documentation are true, accurate, and complete to the best of my knowledge.

I understand that failure to disclose required enrollment information may result in administrative action, including but not limited to enrollment sanctions, corrective action plans, payment suspension, termination from the NC Medicaid program, recoupment of funds, referral to state or federal oversight agencies, or other actions permitted by applicable law and program requirements.

I understand that NC Medicaid and its authorized agents may request additional supporting documentation as necessary.

Office Administrator Authorized Signature: _____

Date: _____