

a General Dynamics Information Technology, Inc. company

NCMMIS Enrollment Specialists Participant User Guide (Provider)

PREPARED FOR:

North Carolina Department of Health and Human Services

DHHS MES VMU

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SUBMITTED BY:

CSRA a General Dynamics Information Technology, Inc. company





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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.





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1.0 Welcome

1.1 COURSE OVERVIEW

Welcome to the Enrollment Specialist (ES) User Role course. This course is applicable to you if you have been assigned the ES user role by your Office Administrator (OA). It will guide you through the processes for completing NCTracks Enrollment, Re-enrollment, Re-verification, Maintain Eligibility, and Manage Change Request (MCR) applications on behalf of the OA.

1.2 COURSE BENEFITS

This course will guide you through an overview of the ES user role when processing Enrollment, Re-enrollment, Re-verification, Maintain Eligibility, and MCR applications. It will also detail the **Status and Management** page, which is used to submit and track these applications.

1.3 COURSE OBJECTIVES

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

- Explain the ES user role.
- Navigate the NCTracks Provider Portal to complete provider Enrollment, Re-enrollment, Re-verification, Maintain Eligibility, and MCR applications.
- Assign completed applications to the OA.

1.4 PREREQUISITES

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

NOTES:







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2.0 Enrollment Specialist User Role

2.1 INTRODUCTION

Many large provider organizations have an owner or managing partner listed as the OA for the providers of that organization. However, the actual job duties of completing and maintaining provider records belong to an ES. The OA can assign the ES user role to one or more NCTracks users to perform these job duties.

The ES user can complete Enrollment, Re-enrollment, Re-verification, Maintain Eligibility, and MCR applications on behalf of the OA. The ES marks the application as complete, and the OA electronically signs and submits the application.

ES users do not have rights to submit Re-enrollment, Re-verification, Maintain Eligibility, and MCR applications, and do not have any signatory or attestation authority. However, the ES can complete and submit all abbreviated MCR application types except the abbreviated Electronic Funds Transfer (EFT) application on behalf of the OA.

2.2 OBJECTIVES

This Participant User Guide provides step-by-step documentation of the processes to complete and assign provider enrollment applications to the OA.

Demonstration sections will have graphic illustrations followed by steps. The numbers on the image 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

NOTES:







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3.0 New Enrollment – Enrollment Specialist

3.1 NAVIGATE TO PROVIDER PORTAL HOME PAGE

The public NCTracks home page displays before the ES user is logged in to the system. To log in to the secure NCTracks Provider Portal, complete the following steps.



Exhibit 1. NCTracks Home Page

Step	Action
1	Select the Providers link. The public Providers page displays.
2	Select the blue lock on the NCTracks Secure Portal image.





RACKS A A English, Español ovider Portal Login Provider Portal Login Important Announcement NCTracks Multi-Factor Authentication (MFA) Updates Coming Soon for Individual & Business Users In accordance with the North Carolina Identity Management (NCID) Citizen Identity Project, NCTracks is changing the User Login process and implementing Multi-Factor Authentication (MFA) updates. Please complete the following steps to update your NCID profile by Sept. 6, 2024, in advance of the MFA updates: These instructions are for Individual and Business users only, not Local and State Government users 1. Login to the MyNCID portal at https://myncidpp.nc.gov/with your NCID Username and Password. 2. You will see the Profile Information page upon successful login. 3. Click on the MFA tab on your profile page. 4. Click on the ADD ENROLLMENTLutton on the bottom right. 5. A pop-up window will appear prompting you to choose an MFA method. Please note that office phone extensions are not supported. 6. Follow the onscreen prompts to add your chosen MFA method. For detailed instructions, including images of each step, refer to the NCID User Guide for MFA. Important Note: Providers who do not currently use MFA will not be impacted at this time. MFA updates will be implemented through a phased approach. Until that time, your current login method will continue to work. However, you are being asked to update your profile to ensure a seamless transition to the new MFA method. You will receive further communication when your MFA is to be updated. If you are an Individual or Business User who currently uses MFA, these updates will impact you on Sept. 15, 2024. Once these updates are implemented you are no longer required to access and maintain MFA using https://mfaportal.nc.gov/nctracksmfa. All profiles, including MFA, will be managed through https://myncid.nc.gov/ after implementation. If you encounter issues during login or authentication, please contact the Department of Information Technology (DIT) helpdesk at 919-754-6000 or 800-722-3946. For more information and training videos, visit the NCID Citizen Identity Project | NCDIT training page. The NCTracks Web Portal contains information that is private and confidential. Only users of legal age or with parental consent authorized by the North Carolina Medicaid Management Information Systems (NC MMIS) may utilize or access NCTracks Web Portal for approved purposes. Any unauthorized use, inappropriate use, or disclosure of this system or any information contained therein is prohibited and may result in revocation of access and/or legal action. If you are not an authorized individual, this private and confidential information is not intended for you. If you are not authorized to access this content, please click 'Cancel'. 0 1 NCTracks Secure Portal NC MMIS retains the right to monitor, record, distribute, or review any user's electronic activity, files, data, or messages. Any evidence of illegal or actionable activity may be disclosed to law enforcement officials. Access the secure NCTRacks Porta By continuing, you agree that you are authorized to access confidential eligibility, enrolment and other health insurance coverage information. Please read more in our Legal and Privacy Policy pages. All users are required to have an NCID to log in to their secure area. An NCID does not grant access to all secure areas. Access to a specified secure area is allowed per the user access rights granted by NCDHHS (State users) or the provider's Office Administrator. Recipient NCIDs does not require additional rights to access Recipient portal. To create/update NCID record, use the appropriate link as per your NCID type. · External Users (Provider or Recipient) click here · State and Local Government employees (State or Fiscal Agent) click here Report Fraud Site Map

Exhibit 2. NCTracks Login Page

of Health and

Step	Action
1	Select the NCTracks Secure Portal button.





USEDNAME*		
USERNAME		
Do	Next Trouble Signing On? on't have an account? Register Now	
Need Help?		
Privacy and Other Policies		Contact Us
WARNING: This and used o Unauthorized access or use	is a government computer system, which may be access only for authorized business by authorized personnel. e of this computer system may subject violators to crimina civil and/or administrative action.	ed of al,

Exhibit 2.1 NCTracks Login Page

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





USERNAME *	
PASSWORD*	
	છ
4 Sign On Trouble Signing On? Don't have an account? Regist	er now
Need Help?	
WARNING: This is a government computer system, and used only for authorized business by authorized in access or use of this computer system may subject vand/or administrative action.	Contact Us which may be accessed personnel. Unauthorized irolators to criminal, civil

Exhibit 2.2 NCTracks Login Page

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

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

Supplemental Points: Passwords are case-sensitive. After three unsuccessful attempts, the user will be locked out; however, NCTracks will provide a contact number to call for access assistance. Multi-Factor Authentication is required. Once the user has entered the User ID and password, the second level authentication is sent via the user's preferred method. For more information on the MFA registration process, please refer to the **NCID Citizen Identity Project** at the following site: <u>https://it.nc.gov/support/ncid/ncid-citizen-identity-project#Tab-Training-4404</u>





The secure **Provider Portal Home** page displays.

Provider Portal	Eligibility	Prior Approval	Claims	Referral	Code Search	Enrollment	Administration	Trading Partner	Payment	Consent For
Message Center for										Subst
Message Center for										00030
		Announce	ment	S					More Annou	Incements
		Date: Mar 29, 2018 12:00:00 AM Attention: All Providers								
		Stay on top of NCTracks - sign up for the newsletter								
1251		The best way to stay on top of updates to NCTracks is to subscribe to the NCTracks Communications and Updates newsletter. If you are not already receiving the newsletter, you can subscribe by clicking on the link under the heading "Sign Up for NCTracks Communications" on the <u>Provider Communications webpage</u> . Signing up will ensure that you receive not only the regular newsletter, but important time-sensitive messages sent via email.								
		WELCOM	E	OFFICE AD	MINISTRATORS	Enroll	MENT			
	1205	Provid	er	U	ser	Status	and			
		Traini	ng	Admin	istration	Manage	ement 1			
Inbox								All Mess	sages (26)	
Provider Status	Message						Date			

Exhibit 3. Provider Portal Home Page

Step	Action
1	Select Status and Management.

The Status and Management page displays.

3.2 STATUS AND MANAGEMENT PAGE – SELECT PAGINATION

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

Note: There will be no change to the **Status and Management** page for users who have access to 50 or fewer NPIs.





ase choose from the	er Enrollment options below t	Status and Management o manage your enrollment status.	
SELECT PAGINATION			
Your NCID has acco The NPIN/Atypical I will be displayed in Note: The Saved /	ess to more than IDs in the Submi a pagination for soplications and ers (Displaying	50 NPIs/Atypical IDs. Ited Applications, Manage Change Reques mat. They are sorted in NPI/Atypical ID o Enrolment Specialist Applications sections Providers 101 - 150	t, Re-enroll, Re-verification, Maintain Eligibility, and Fingerprinting Required sections rder. Use the pagination drop-down to view 50 at a time. s are not paginated.

Exhibit 4. Status and Management Page – Select Pagination

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

3.2 STATUS AND MANAGEMENT PAGE – ES APPLICATIONS

The ES user can begin a new enrollment application from the **Status and Management** page.

The ES user can access the **Online Application** option through the **Quick Links** on the left side of the page or from the **Enrollment** tab.



Exhibit 5. Status and Management Page





3.3 ONLINE PROVIDER ENROLLMENT APPLICATION PAGE

On the **Online Provider Enrollment Application** page, the ES user will enter the provider's ZIP code in order for NCTracks to determine if the provider is either an In-State, Border, Out-of-State (OOS), or Ordering, Prescribing, and Referring (OPR) provider. The ES user must also select the appropriate **Provider Enrollment Application Type**.

On	line Provider Enrollment Application	AA 6	Help
* in	dicates a required field	Legend	
	PROVIDER LOCATION		?
1	Please enter the 9-digit ZIP Code (ZIP +4) of your primary practice location for determination of In-State, Border, or Out-of-State enrol	ment.	
	1 * ZIP Code: 00000-0000		
2	* PROVIDER ENROLLMENT APPLICATION TYPE		2
	Individual		
Ó	An individual provider is a person enrolled directly who may have an affiliation with an organization or may bill independently for servic completing the Individual Provider Enrollment application, you will be given the opportunity to also enroll as a Primary Care Provider (P CCNC/CA program if your provider type qualifies you to be a PCP.	es. When you CP) in the	are
	Organization		
0	An Organization is an entity, facility, or institution that may be an affiliation of individual providers. When you are completing an Organ Enrollment application, you will be given the opportunity to also enroll as a PCP in the CCNC/CA program if your provider type qualifies	zation Provide you to be a P	er CP.
	Atypical Organization		
¢.	Are you an atypical organization? As defined by CMS: Atypical providers are providers that do not provide health care, as defined under Federal regulations at 45 CFR section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of aty reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA defin care and therefore cannot receive an NPI.	r HIPAA in pical providers sition of health	s
	Billing Agent		
0	Billing Agents and Clearinghouses are third party entities—businesses—that submit information directly to CSRA is the NC DHHS Fiscal an enrolled provider.	Agent on beha	alf of
		2	
	Please be sure to co- required fields with vale	nplete all No	ext 10

Exhibit 6. Online Provider Enrollment Application Page

Step	Action
1	ZIP Code: Enter ZIP Code .
2	Provider Enrollment Application Type: Select Individual, Organization, Atypical Organization, or Billing Agent.
3	Select Next to continue.

3.4 ORGANIZATION BASIC INFORMATION PAGE

The **Organization Basic Information** page captures an Organization's identifying information as well as Doing Business As (DBA) and ownership information. If the provider is enrolling as an Individual provider, skip to <u>Section 3.5, Individual Basic Information Page</u>.





С	rganization Basic	: Information			A A	<u>Help</u>
*	indicates a required field				Legend	•
1	IDENTIFYING INFORMATION * Organization Name:					?
	* EIN: * Email:	00-0000000 * Month	* NPI: of Fiscal Year	0000000000 Select One	•	
	ZIP Code:	27707-0000	End:			
2	Doing Business As (DBA) * Do you operate under O Yes O No	er a trade or company name?				?
						*
3	OWNERSHIP INFORMATION		_			2
	* Business Type:	Select One Select One CITY/MUNICIPALITY	lters page con	tent		+
	- Office Administrator (A	CORPORATION FEDERAL INDIAN HEALTH SERVICES				?
	Individual authorized to role currently belongs to	LOCAL GOVERNMENT AGENCY NON-PROFIT	ecisions on	behalf of applyi	ing provider. Thi	5
	* Last Name:	PARTNERSHIP STATE	First Name:	MICHELLE		

Exhibit 7. Organization Basic Information Page #1

Step	Action
1	Identifying Information: Enter Organization Name, EIN, NPI, Email, and Month of Fiscal Year End.
2	Doing Business As (DBA): Select Yes or No . If Yes is selected, enter DBA Name and enter Years Doing Business Under This Name .
3	 Ownership Information: Select the Business Type from the drop-down menu: City/Municipality: Select if the organization is owned by a City or a Municipality. Corporation: Select 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 if ownership falls within the jurisdiction of the federal government. Indian Health Services: Select if ownership falls within the jurisdiction of the Indian Health Services. Limited Liability Corporation (LLC): Select if the organization is a Limited Liability Corporation (LLC). Local Government Agency: Select if the organization is owned by a City or a Municipality. Non-Profit: Select if the organization is a non-profit enterprise. Partnership: Select if the organization is a General Partnership, or a Limited Partnership, where two or more people have created this business entity.



Step

North Carolina Medicaid Management Information System (NCMMIS)



• State: Select if the entity is owned by the state in which it operates.

EGISTERING WITH NC SECRETARY Are you required by law to r	OF STATE egister with NC Secretary of State?	
🖲 Yes 🔘 No		
* Secretary of State ID #:		
	1	
FFICE ADMINISTRATOR (AUTHORI	ZED INDIVIDUAL)	
Individual authorized to receiperson populated below.	ve information or make business de	cisions on behalf of applying provider. This role currently belongs to the
* Last Name:		* First Name:
Middle Name:		Suffix: Select One 💌
	(Enter your full middle name)	
* Contact Email:		
* Office Phone #:	(000) 000-0000 ext	Office Fax #: (000) 000-0000
# Liter ID (NCID):		and an . (land) and store
 Is this contact person an Or Owner Managing Employed 	vner or Managing Employee? Joyee	
FFECTIVE DATE REQUESTED		
The effective date is the earlied days prior to the date that a discussion or the current date that a discussion of the current date of the curren	ist date a provider may begin billing complete Provider Enrollment Packe of your letter of endorsement.	for services. The effective date of enrollment may not be more than 36 t is received and may not precede, as applicable, the current date of you
Note: CCNC/CA participation	effective date may not be retroactiv	rely requested.
7 * Effective Date:	04/24/2015	
-		

Exhibit 8. Organization Basic Information Page #2

Step	Action
4	Registering with NC Secretary of State: Select Yes or No; If Yes, enter Secretary of State ID #.
5	Office Administrator (Authorized Individual): Enter Last Name, First Name, Contact Email, and Office Phone #, and select User ID (NCID). Select the checkbox next to the attestation statement. Note: The Office Administrator information is pre-populated with the OA's name, NCID, and e-mail address from NCTracks user provisioning.
6	Is this contact person an Owner or Managing Employee?: Select Owner or Managing Employee.
7	Effective Date Requested: Enter Effective Date.
8	Select Next to continue.





3.5 INDIVIDUAL BASIC INFORMATION PAGE

		L	egend
IDENTIFYING INFORMATION			
* Last Name:		* First Name:	
Middle Name:		Suffix: Select One V	
	(Enter your full middle name)		
* Date of Birth:	mm/dd/yyyy	* SSN:	
* Gender:	Select One -· V	* NPI: 000000000	
* Email:			
□I attest that I have given my	full legal name, and I do not have a middle name.		
- Employer Identification Number	(EIN)		
* Will your income be reported to • Yes O No	an EIN?		
* EIN:	00-000000		
* DBA Name:			
* Years Doing Business Under This Name:			
Rendering/Attending Only Provi	DER		
* Are you a Rendering/Attending O Yes O No	Only provider?		
Ownership Information			
* Business Type:	Select One 🗸		
-Office Administrator (Authorize	Select One v		
OFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive i populated below.	Select One v	ing provider. This role currently belongs to the per	son
OFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive i populated below. * User ID (NCID):	Select One v nformation or make business decisions on behalf of apply Select One v	ing provider. This role currently belongs to the per	son
• Business Type: OFFICE ADMINISTRATOR (AUTHORIZE: Individual authorized to receive i populated below. * User ID (NCID): * Last Name:	Select One	ing provider. This role currently belongs to the per * First Name:	son
• Business Type: OFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive i populated below. * User ID (NCID): * Last Name: Middle Name:	Select One	ing provider. This role currently belongs to the per * First Name:	son
Business Type: OFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive i populated below. * User ID (NCID): * Last Name: Middle Name:	Select One INDIVIDUAL Select One (Enter your full middle name)	ing provider. This role currently belongs to the per * First Name: Suffix: Select One •	son
* Business Type: OFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive i populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email:	Select One	ing provider. This role currently belongs to the per * First Name: Suffix: Select One v * SSN:	son
Business Type: OFFICE ADMINISTRATOR (AUTHORIZE: Individual authorized to receive i populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #:	Select One Select One Select One (Enter your full middle name) (000) 000-0000 ext.	ing provider. This role currently belongs to the personal structure of	son
Business Type: OFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive i populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered	Select One D INDIVIDUAL) nformation or make business decisions on behalf of apply Select One (Enter your full middle name) (000) 000-0000 ext. the full legal name of the individual, and the individual do	ing provider. This role currently belongs to the per * First Name:	500
Business Type: OFFICE ADMINISTRATOR (AUTHORIZE) Individual authorized to receive i populated below. * User ID (INCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered EFFECTIVE DATE REQUESTED	Select One INDIVIDUAL) formation or make business decisions on behalf of apply Select One (Enter your full middle name) (000) 000-0000 ext. the full legal name of the individual, and the individual do	ing provider. This role currently belongs to the personal sector of	son
Business Type: OFFICE ADMINISTRATOR (AUTHORIZE) Individual authorized to receive i populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered EFFECTIVE DATE REQUESTED The effective date is the earliest to the date that a complete Pro current date of your letter of en Note: CCNC/CA participation effective for a for the formation of the formation	Select One D INDIVIDUAL) nformation or make business decisions on behalf of apply Select One (Enter your full middle name) (O00) 000-0000 ext. (O00) 000-0000 ext. the full legal name of the individual, and the individual do the full legal name of the individual do the full legal name of the individual, and the individual do the full legal name of the individual, and the individual do the full legal name of the individual, and the individual do the full legal name of the individual, and the individual do the full legal name of the individual, and the indiv	ing provider. This role currently belongs to the personal sector of	300 days or the
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	Select One D INDIVIDUAL) Select One (Enter your full middle name) (Course of the individual, and the individual do (Course of the individual, and the individual, and the individual do (Course of the individual, and the individual do (Course of the individual, and the individual, and the individual do (Course of the individual, and the individual, and the individual do (Course of the individual, and the i	ing provider. This role currently belongs to the per * First Name:	son days

Exhibit 9. Individual Basic Information Page #1





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

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

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

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

Step	Action
1	Identifying Information: Enter Last Name, First Name, Date of Birth, SSN, Gender, NPI, and Email.
	Note: Individuals enter their Legal Name (Last, First, and Middle), if applicable.
2	Select the attestation checkbox if you have given your full legal name and you do not have a middle name.
3	Employer Identification Number (EIN): Will your income be reported to an EIN?: Select Yes or No ; if Yes , enter EIN . Do not enter the EIN of an Organization or group to which you may be affiliated.
	Note : A DBA is required when an Individual provider reports their income to an EIN.
4	Doing Business As (DBA): Select Yes or No ; if Yes , enter DBA Name and Years Doing Business Under This Name .
	Note : If you select Yes , the page displays a field requesting the number of "Years Doing Business Under This Name".
	The DBA Name field only allows the following characters:
	 Alpha (A – Z)
	 Numeric (0 – 9)
	Hyphen (-)
	Ampersand (&)
5	Rendering/Attending Only Provider: Select Yes or No.





OWNERSHIP INFORMATION		
8 * Business Type	- Select One -	
a busiliess type.	- Select One -	
	SELF (INDIVIDUAL FILING UNDER A SSN)	
	SINGLE-OWNER LLC	
OFFICE ADMINISTRATOR (AUTHORIZ	SOLE PROPRIETOR	
Individual authorized to receive populated below.	information or make business decisions on behalf of applying prov	ider. This role currently belongs to the perso
Authorized Individual is the second secon	e same as enrolling provider	
* Last Name:	* First Name	: MICHELLE
Middle Name:	Suffix	Select One 💌
	(Enter your full middle name)	
t Contrat Frank	(encer you full middle flame)	
* Contact Email:		
* Office Phone #:	(919) 333-2222 ext. Office Fax #	: (000) 000-0000
* User ID (NCID):	uatdemonrovider	
I attest that I have entere	d the full legal name of the individual, and the individual does not h	nave a middle name.
EFFECTIVE DATE REQUESTED		
	t date a provider may begin billing for services. The effective date (of oprollmont may not be more than 265 days
The effective date is the earlies	clace a provider may begin billing for services, the effective date (of enrollinencinay not be more than 505 days
The effective date is the earlies prior to the date that a complete that a complete that a complete the date th	e Provider Information Packet is received and may not precede, as	applicable, the current date of your licensure
The effective date is the earlies prior to the date that a complet or the current date of your lette	re Provider Enrollment Packet is received and may not precede, as r of endorsement.	applicable, the current date of your licensure
The effective date is the earlies prior to the date that a complet or the current date of your lette Note: CCNC/CA participation eff	e Provider Enrollment Packet is received and may not precede, as a rof endorsement.	applicable, the current date of your licensure
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The effective date is the earlies prior to the date that a complet or the current date of your lett Note: CCNC/CA participation ef B Effective Date:	e Provider Enrollment Packet is received and may not precede, as er of endorsement. ective date may not be retroactively requested.	applicable, the current date of your licensure
The effective date is the earlies prior to the date that a complet or the current date of your lette Note: CCNC/CA participation ef B Effective Date:	e Provider Enrollment Packet is received and may not precede, as er of endorsement. fective date may not be retroactively requested.	applicable, the current date of your licensure
The effective date is the earlies prior to the date that a complet or the current date of your lett Note: CCNC/CA participation ef B Effective Date:	e Provider Enrollment Packet is received and may not precede, as er of endorsement. fective date may not be retroactively requested.	applicable, the current date of your licensure

Exhibit 10. Individual Basic Information Page #2

Step	Action
6	 Ownership Information: Select the Business Type from the drop-down menu. If No is selected for the question "Will your income be reported to an EIN?" the user is able to select the option of Self (Individual Filing Under an SSN) or Sole Proprietor from the Business Type drop-down menu. If Yes is selected for the question "Will your income be reported to an EIN?", the user is able to select one of the available options listed in the Business Type drop-down menu: Self – Select this type if you are an Individual filing under an SSN. Single-Owner LLC – Select this type (filing status) if you are an Individual who intends to operate as a sole proprietor and act as the sole owner and manager. Sole Proprietor – Select this type (filing status) if you are an Individual filing under an EIN.
7	Office Administrator (Authorized Individual): Select the Authorized Individual is the same as enrolling provider checkbox if the Individual provider is the OA. If not selected, the OA is always assumed to be a managing employee. Enter Last Name , First Name , Contact E-mail , SSN , Office Phone , and User ID (NCID) .
8	Effective Date Requested: Enter Effective Date.
9	Select Next to continue.





Note: If the ES user is associated with more than one OA, a **Select Office Administrator** drop-down menu will display. After the ES user selects the OA, the Office Administrator information will be populated with the OA's name, NCID, and e-mail address from NCTracks user provisioning.

3.6 TERMS AND CONDITIONS PAGE

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

3.7 BASIC INFORMATION COMPLETED PAGE

The **Basic Information Completed** page notifies the applicant that the basic information has been completed and provides instructions for resuming an In Process application if the applicant chooses not to complete the application at this time.

3.8 PREVIOUS HEALTH PLAN INFORMATION PAGE

The **Previous Health Plan Information** page captures the various past North Carolina Department of Health and Human Services (NC DHHS) IDs for health plans in which the applicant was previously enrolled.

3.9 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.

	🗟 Welcom	e, Vijay Saxena . (<u>Log out</u>)
CILIRACKS		<u>NCTracks Help</u>
Provider Portal	Eligibility Prior Approval Claims Referral Code Search <u>Enrollment</u> Administration Trading Partner Payme	ent Consent Forms Training
Home Provider Enrollment O	nline Provider Enro Iment Ap	
Provider Enrollment	Health / Benefit Plan Selection	🖨 АА Неір
NOTE: Data is not saved unless the 'Next' button is act[vated.	* indicates a required field	Legend 🔻
Contact CSRA Call center 🖀	Which NC DHHS Health Plan(s) are you applying for at this time?	
Individual Basic Information	What are the qualifications and requirements for the NC DHHS Health Plans?	
Terms and Conditions	See <u>Provider Permission Matrix</u> .	
Previous Health Plan	DIVISION OF HEALTH BENEFITS, DIVISION OF PUBLIC HEALTH, OFFICE OF RURAL HEALTH	?
Health/Benefit Plan Selection	Please select any coverage types for which you wish to enroll by checking the corresponding box.	
Addresses	If you are a Behavioral Health provider intending to contract with a Local Management Entity-Managed	Care Organization
Review Application	(LME-MCO), contact the LME-MCO before completing an application in NCTracks. Enrollment in Medicaid contract with a LME-MCO.	does not guarantee a
	If applying for Medicaid, a \$100 NC Application fee will be required. Upon application submission, you will Paypoint to make the payment.	be directed to
	Division of Health Benefits (DHB)	
	Medicaid	
	Division of Public Health (DPH)	
	2 Infant Toddler Sickle Cell	
	Early Hearing Detection Intervention AIDS Drug Assistance Program	
	Office of Rural Health Office of Rural Health	
	y	
		†
	((Previous Please be sure required fields with	to compile II Next »
		Save Draft Delete Draft

Exhibit 11. Health / Benefit Plan Selection Page





Step	Action
1	Opt out of any coverage by clearing the appropriate checkbox: Division of Health Benefits (DHB): Medicaid.
2	Opt out of any coverage by clearing the appropriate checkbox: Division of Public Health (DPH): Infant Toddler, Sickle Cell, Early Hearing Detection Intervention, AIDS Drug Assistance Program.
3	Opt out of any coverage by clearing the appropriate checkbox: Office of Rural Health and Community Care (ORHCC): Migrant Health .
4	Select Next to continue.

3.10 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. The OOS Lite Organization only has access to the **Ownership Information** page when the OA is an owner, and additional owners are not allowed.





MNETSNIP INTORMATIC	on			Legend
o you have one or more Shareh	olders/Partners with 5% or mo	re ownership? Yes		
SHAREHOLDER/PARTNER INFORMATI	ON			
+ INDIVIDUAL -				
+ INDIVIDUAL -				
- INDIVIDUAL -	NEWLY ADDED			
Last Name :		First Name :		
Middle Name :		Suffix :		
Date of Birth:		SSN :	***_**-	
Gender :				
Email :		Phone Number :		
$\overline{\mbox{\footnotesize M}}$ I attest that I have entered	ed the full legal name of the ind	ividual, and the individual does not	have a middle name.	
Address Line 1 :				
Address Line 2 :				
City :				
State :				
ZIP Code :				
Relationship to Another Disclosing Person :	None	Percent of Ownership/Control Interest :	5 %	
Begin Date :	09/16/2015	End Date :		
Add Shareholder/Partner Please complete the required # This shareholder/partner is:	information for each sharehold	er/partner with 5% or more owner	ship.	
🔘 an individual 🛛 🎯 a busine	255			
Business Information				
* Business Legar Name.	00-000000			
* Address Line 1:				
Address Line 2:				
* City:				
* State:	NORTH CAROLINA			
* ZIP Code:	00000-0000			
				Verify Address
* Percent of Ownership/Control Interest:	%			
* Begin Date:	mm/dd/yyyy			
				Add Clear
				4
Previous			Please be sure to	complete all Nevt

Exhibit 12. Ownership Information Page



Step	Action
1	Shareholder/Partner Information: Do you have one or more Shareholders/Partners with 5% or more ownership?: Select Yes or No ; if Yes , Managing Relationships displays.
2	Select Edit to edit an existing Managing Relationship 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	 Add Shareholder/Partner: Select the radio button for an individual or a business. If an individual is selected, 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 Add. If a business is selected, enter Business Legal Name, EIN, Address, City, State, ZIP Code, Percent of Ownership/Control Interest, and Begin Date. Then select Add.
4	Select Next to continue.
Note	The Ownership Information page displays only for OOS Organizations when the OA is an owner. No other owners can be added to the record.

3.11 ADDRESSES PAGE

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

Note: OPR Lite providers are not required to add additional service locations.

Provider Enroliment	Addresses				🚔 AA Me
NOTE: Data to not saved unless the 'Neted' Suffer to schedels. Contact (1984-Call service 📑	 Indicates a required field 				Legend
 Interaction Interaction 	This is the primary physical location where wher updating the fields, please click the fi	annuce will be rendered, or in the cas Sever Judion.	e of multile services, where ma	паретнет/паретивно осса	• (f)
V CONTRACTOR					
Installent fan Janche Mateure	Office Phone #: Address Life 1	est.	Office Fax #:		

Exhibit 13. Addresses Page #1

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





and the second se	I NORTHAMPTON	ONSLOW	ORANGE	
PAMLICO	PASQUOTANK	PENDER	PERQUIMANS	
PERSON	III PITT	E POLK	III RANDOLPH	
RICHMOND	ROBESON	C ROCKINGHAM	ROWAN	
RUTHERFORD	III SAMPSON	SCOTLAND	III STANLY	
STOKES	SURRY	SWAIN	TRANSYLVANIA	
TYRRELL	E UNION	VANCE	WAKE	
WARREN	WASHINGTON	C WATAUGA	C WAYNE	
II WILKES	WILSON	2 YADKIN	III YANCEY	
Il provider records with t	he same Employee Identification Nu EIN, Upon application approval, all	mber (EIN) must have the same records with the same EIN will b	1099 Reporting Address. You only e updated with the new address.	need t
Il provider records with t ubmit one application per Do you have a separate	he same Employee Identification Nu EIN. Upon application approval, all Pay-To address?	mber (EIN) must have the same records with the same EIN will b	1099 Reporting Address. You only e updated with the new address.	need t
Il provider records with t ubmit one application per Do you have a separate Yes No	he same Employee Identification Nu - EIN. Upon application approval, all Pay-To address?	mber (EIN) must have the same records with the same EIN will b	1099 Reporting Address. You only e updated with the new address.	need t
Il provider records with t ubmit one application per Do you have a separate O Yes O No	he same Employee Identification Nu EIN. Upon application approval, all Pay-To address?	mber (EIN) must have the same records with the same EIN will b	1099 Reporting Address. You only e updated with the new address.	need t
Il provider records with t ubmit one application per Do you have a separate Yes No RRESPONDENCE ADDRESS —	he same Employee Identification Nu EIN. Upon application approval, all Pay-To address?	mber (EIN) must have the same records with the same EIN will b	1099 Reporting Address. You only e updated with the new address.	r need t

Exhibit 14. 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 . Note : All provider records with the same EIN must have the same 1099 Reporting/Pay-To Address. If you need to update the address, submit an MCR application. You need to submit only one application per EIN. Upon application approval, all records with the same EIN will be updated with the new address.
4	Correspondence Address: Do you have a separate correspondence address?: Select Yes or No .



(



• Service Loca	TION -	NEWLY ADDED		
Add Service Location				
Please complete i	ill the required fields an	d click the Add button.		
Service U	ocation Name:			
• 0	Hice Phone #:	ext.	Office Fax #1	
Address				
	Address Line 1:			
	Address Line 2:			
	 Oby: 			
	· State:	~		
	• ZIP Code:		County	
				Yerify Add
				6 🔤
				•
hevious				Please be sure to complete 7
				he and the second se

Exhibit 15. Addresses Page #3

Step	Action
5	This field is for adding any additional service locations that are required. 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). You must select Add to add the service location to your file.
6	Select Add to add a service location.
7	Select Next to continue.
Note	Additional service locations are not required for OPR Lite providers.

3.12 TAXONOMY CLASSIFICATION PAGE

The **Taxonomy Classification** page allows providers to add taxonomy code set(s) (provider type, classification, and area of specialization). Select the taxonomy code(s) under which the provider will be conducting business with NCTracks for each service location. All taxonomies selected should have been previously reported to the National Plan and Provider Enumeration System (NPPES) when the provider enumerated this NPI.

Note: Taxonomies that are identified as Moderate or High categorical risk levels will have additional enrollment criteria that must be met.

Provider Portal	Eligibility Prior Approval Cl	aims Referral Public Realth	Errolment Administration Code Search	PORTAL-DEV	
• Home • Provider Enrolment • Online Provi	ider Enrollment Ap				
Provider Enrollment	Taxonomy Classifica	tion		🚔 A A Helo	
NOTE: Data is not saved unless the 'Next' button is activated.	indicates a required field			Legend -	
Contact CSRA Call center 🔤	= SERVICE LOCATIONS				
	Select		Location	Form Status	
Organization Basic Information	1 .			Incomplete	
Terms and Conditions	0			Incomplete	
Contract Health Flat	0			Incomplete	
Health Benefit Fian Selection	La contra contra			6	
Osneshia Information	To complete information for	each service location, selec	t the appropriate location then click the "Edi	t Location" button.	
🖌 éddamen				Edit Location	
Taxonomy Classification					







Step	Action
1	Service Locations: Select the Location for which you want to add taxonomy code set(s).
2	Select Edit Location.

1	Taxonomy Classification	
	3 School Based Health Center	?
	* Is your organization a School Based Health Center (SBHC)?	
	© Yes ⊛ No	
		+

Exhibit 17. Taxonomy Classification Page #2

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

Type, Classification and Area of Specialization
Please select a Provider Type, Classification and Area of Specialization from the following drop-down lists that best describe the services you will be rendering. You may enter up to 15 Taxonomy Classifications.
+ TAXONOMY CLASSIFICATION - 193200000X - MULTI-SPECIALTY
* TAXONOMY CLASSIFICATION - 282N00000X - GENERAL ACUTE CARE HOSPITAL
Add Taxonomy Classification
Please complete all the required fields and click the Add button.
* Provider Type: Select One * Classification: Select One
* Area of specialization: - Select One •
Add Clear
Once all taxonomies have been added, click the "Save Location" button to save.
Save Location
Please be sure to complete all required fields with valid content. Next 3)
Save Draft Cancel Enrollment

Exhibit 18. Taxonomy Classification Page #3

Step	Action
4	Add Taxonomy Classification: Using the drop-down menus, select Provider Type , Classification , and Area of Specialization (if applicable).
5	Select Add to add a Taxonomy Classification. Note : Repeat this process to add multiple taxonomy codes. Up to 15 taxonomy codes can be entered per location.
6	Select Save Location after all taxonomies have been added.
7	Select Next to continue.





3.13 ADD SERVICES AND ENDORSEMENTS PAGE

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

Provider Portal	Eligibility Prior Approval C	airns Referral	Public Health Enrolline	Administration	Code Search	PORTAL-DEV		
* Home * Provider Enrollment * Online Provider	Enrollment Ap							
Provider Enrollment	Add Services and Er	dorseme	nts					ali A A Helo
NOTE: Data is not saved unless the 'Next' button is activated.	 indicates a required field 							Legend *
Contact CORA Call center	- SERVICE LOCATIONS							
Operation Basic Information	Select			Location				Form Status
Zama and Conditions	U .							Incomplete
Previous Health Flat	0							Incomplete
Health Benefit Plan Selection	0							Encomplete
Overentria Information	To complete information fo	r each service	location, select the app	opriate location t	hen dick the "	Edit Location	button.	2
2 Addresses			interest one app		and the second second	Care Colorbon	ar an	
Tennery Classification								Edit Location

Exhibit 19. Add Services and Endorsements Page #1

Step	Action
1	Service Locations: Select the Location for which you want to add services and endorsements.
2	Select Edit Location.
Note	This page is not displayed for OPR Lite providers.

TAXON	ONY CLASSIFICATION - 251800000X - CASE MANAGEMENT
 Service 	зе Туре
≭Doy ⊛Ye	iou wish to add CAP/DA services OR CAP/C services ? is © No
Select	Service Type(s) CAP/DA services CAP/C services 7
Which	CAP/DA services do you wish to provide for this taxonomy at this location?
= C/	AP/DA SERVICES Service Name
V	Case Management
= c/	AP/C services
Select	Service Name
Select	Service Name Vehicle Modification
Select	Service Name Vehicle Modification Case Management
Select V V	Service Name Vehicle Modification Case Management Care Giver Training
Select V V	Service Name Vehicle Modification Case Management Care Giver Training Community Transition Funding
Select	Service Name Vehicle Modification Case Management Care Giver Training Community Transition Funding

Exhibit 20. Add Services and Endorsements Page #2



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

3.14 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.

Provider Portal	Eligibility Prior Appro	val Claims Refe	rral Public Health	Incolment Ad	Initiatration	Code Search	PORTAL-DEV		
* Hame * Proxider Enrollment * Online Provid	ler Enrollment Ap								
Provider Enrollment	Accreditation								
NOTE: Data is not saved unless the 'Next' button is activated.	Indicates a required field								Legend *
Contact CSRA Call center	- SERVICE LOCATED	NS							
	Select			Locati	ion				Form Status
Opercipation Basic Information									Incomplete
Terms and Conditions	0								Incomplete
Previous Health Flam	0								Encomplete
🖌 Health Benefit Plan Selection									
Senechia Information	To complete informat	ion for each serv	ice location, select t	he appropriate	location the	n dick the "E	dit Location" b	utton.	2
🖌 Addresses									Edit Location
Taxonomy Classification									

Exhibit 21. Accreditation Page #1

Step	Action
1	Service Locations: Select the Location for which you want to add accreditations, certifications, and/or licenses.
2	Select Edit Location.
Note	Providers other than OPR Lite providers with multiple service locations that require the same accreditation, certification, and/or license can copy the information to all locations by selecting the checkbox shown in Exhibit 21 .





	ation, fill out this form section then click 'Save Loc	ition' in lower right.	
lease provide certification, licen	e, accreditation, and endorsement information that	qualifies you to render services.	
CREDITATIONS			
f one or more accreditations is r	quired for your taxonomy, enter the accreditations	equired fields and click the Add button.	
Taxonomy 261QB0400X - Birthi	g requires the following Accreditation Type:		
Commission for Accreditation	of Free-standing Birthing Centers		
Accreditation - Commissio	FOR ACCREDITATION OF FREE-STANDING BIRTHING	CENTERS	
Accreditation Type:	Commission for Accreditation of Free-standing Bi	thing Centers	
* Accreditation #:	3	Evaluation Date:	-
Copy this accreditation to all		Expiration Date: mm/dd/yyyyy	20
service locations:			
			-
			Add CI
			4 Add C
TIPICATIONS			4 Add C
TIRCATIONS one or more certifications is req	ired for your taxonomy, enter the certifications requ	red fields and click the Add button.	4 Add C
TIRCATIONS one or more certifications is req axonomy 2610F0050X - Family	ired for your taxonomy, enter the certifications requ Vanning, Non-Surgical requires the following Certi	red fields and click the Add button. fication Type:	
TIPCATIONS one or more certifications is req axonomy 261QF0050X - Family Planned Parenthood Agency E	ired for your taxonomy, enter the certifications requ Nanning, Non-Surgical requires the following Certi y Planned Parenthood Federation of America	red fields and click the Add button. fication Type:	4 Add C
TIRCATIONS one or more certifications is req exonomy 261QF0050X - Family Planned Parenthood Agency E CERTIFICATION - PLANNED PAG	ired for your taxonomy, enter the certifications requi Nanning, Non-Surgical requires the following Certi y Planned Parenthood Federation of America NTHOOD AGENCY BY PLANNED PARENTHOOD FEDERA	red fields and click the Add button. fication Type: TOM OF AMERICA	4 Add C
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Exhibit 22. Accreditation Page #2

Step	Action
3	Add Accreditation: Enter Accreditation Type , Accreditation # , Effective Date , and Expiration Date . If your accreditation does not have an expiration date, leave this field blank.
4	Select Add.
5	Add Certification: Enter State , Certification # , Effective Date , and Expiration Date . If your certification does not have an expiration date, leave this field blank.
6	Select Add.
Note	If you have multiple service locations that require the same accreditation, certification, and/or license, you can copy the information to all locations by selecting the checkbox shown in Exhibit 22 .





conomy 253300000X - Foster Ca	are Agency requires the following Lic	cense Type:				
Child Placing Agency By NC 0	Division of Social Services					
LICENSE - CHILD PLACING AGE	NET BY NC DIVISION OF SOCIAL SERV	VICES				
License Agency:	NC Division of Social Services					
License Type:	Child Placing Agency					
* State:	NORTH CAROL					
* License #:		-				
* Effective Date:	mm/dd/yyyy		* Expiration Date:	mm/dd/yyyy	25	
opy this license to all service.						
Incations:						
locations						-
locations						B Add Clear
locations:						B Add Clear
locations:	n down list and provide the licence of	umber.				B Add Clean
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locations: License liect a license type from the dro License Agency:	p down list and provide the license n	umber.				6 Add Clean
locations: License License type from the dro License Agency: License Type:	p down list and provide the license n Select One Select One	umber.				B Add Ciear
locations: License License type from the dro License Agency: License Type: State:	p down list and provide the license n Select One Select One NORTH CAROL	umber.				B Add Ciew
locations: License License type from the dro License Agency: License Type: State: License #:	p down list and provide the license n Select One Select One NORTH CAROL	umber.				8 Add Ciew
locations: License License type from the dro License Agency: License Type: State: License #1 Effective Oste:	p down list and provide the license n Select One Select One NORTH CAROL mm/dd/yyyy	umber.	Expiration Date:	[mm/dd/yyyy	12	8 Add Clea
locations: License type from the dro License Agency: License Type: State: License #1 Effective Date:	p down list and provide the license n Select One Select One NORTH CAROL mm/dd/yyyyy	umber.	Expiration Date:	mm/dd/yyyy		8 Add Cira
locations: License type from the dro License Agency: License Type: State: License #1 Effective Date:	p down list and provide the license m Select One Select One NORTH CAROL	umber.	Expiration Date:	mm/dd/yyyy		B Add Circu

Exhibit 23. Accreditation Page #3

Step	Action
7	Expand License: Select Edit. Enter State, License #, Effective Date, Expiration Date.
8	Add License: Select License Agency, select License Type, enter State, License #, Effective Date, Expiration Date.
9	Select Add.
10	Select Save Location.
11	Select Next to continue.

3.15 COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS PAGE

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

3.16 PHYSICIAN EXTENDERS PARTICIPATION PAGE

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

3.17 PREVENTIVE AND ANCILLARY SERVICES PAGE

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

3.18 HOURS PAGE

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





3.19 SERVICES PAGE

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

3.20 AGENTS/MANAGING EMPLOYEES PAGE

The **Agents/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).





	Employees	🖨 AA H
ndicates a required field		Legend
ELATIONSHIP DISCLOSURE		
As required by 42 CFR 1002.3, member, and Electronic Funds	providers must disclose the following for each individual officer, managing em Transfer (EFT) authorized individual.	ployee, director, board
Failure to provide the required	nformation may result in a denial for participation.	
Does the applicant have any ag	ent(s) and/or managing employee(s)? Yes	
Managing Relationships		
Please add all managing relati	onships below.	
- MANAGING RELATIONSHI	- (Authorized Individual Managing Contact) N	WLY ADDED
Last Name :	First Name :	
Middle Name :	Suffix :	
Date of Birth :	SSN : ***-**-	
Email :	Phone Number :	
Business Relationship :	Agent	
☑ I attest that I have enter	ed the full legal name of the individual, and the individual does not have a mid	dle name.
Address Line 1		
Address Line 1 :		
Address Line 2 :		
City :		
State :	NORTH CAROLINA	
Add Relationship	od fields and slick the Add hutton	•
Please complete all the require	eu neius anu CICK the Add Dutton.	
* Last Name:	* First Name:	
* Last Name: Middle Name:	First Name: Suffix: Select C	ne 💌
* Last Name: Middle Name: * Date of Birth:	First Name: Suffix: Select C (Enter your full middle name) mm/dd/ueau SSN-	ne 💌
* Last Name: Middle Name: * Date of Birth: * Email:	K First Name: Suffix: Select C (Enter your full middle name) mm/dd/yyyy SSN: K Phone Number: (000) 000	ne 💌
* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship:	* First Name: Suffix: Center your full middle name) mm/dd/yyyy * SSN: * Phone Number: (000) 000-	ne 💌
* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship:	* First Name: Suffix: (Enter your full middle name) mm/dd/yyyy * SSN: * Phone Number: (000) 000- Select One d the full legal name of the individual, and the individual does not have a middle	ne 💌 0000
* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship:	* First Name: Suffix: CEnter your full middle name) mm/dd/yyyy * SSN: * Phone Number: (000) 000- Select One d the full legal name of the individual, and the individual does not have a middle	ne 💽
* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship: I attest that I have entered * Address Line 1:	* First Name: Suffix: Suffix: (Enter your full middle name) mm/dd/yyyy * SSN: * SSN: * Phone Number: (000) 000- Select One * d the full legal name of the individual, and the individual does not have a middle	ne 💌
* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship: I attest that I have entered * Address Line 1: Address Line 2:	First Name: Suffix: Select C (Enter your full middle name) mm/dd/yyyy SSN: * Phone Number: (000) 000- Select One d the full legal name of the individual, and the individual does not have a midd	ne 💌
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* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship: I attest that I have entered * Address Line 1: Address Line 2: * City: * State:	* First Name: Suffix: Select C (Enter your full middle name) mm/dd/yyyy * SSN: * Phone Number: (000) 000 Select One d the full legal name of the individual, and the individual does not have a midd d the full legal name of the individual, and the individual does not have a midd	ne 💌
* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship: I attest that I have entered * Address Line 1: Address Line 2: * City: * State: * ZIP Code:	* First Name: Suffix: Select C (Enter your full middle name) mm/dd/yyyy * SSN: * Phone Number: (000) 000 Select One d the full legal name of the individual, and the individual does not have a midd d the full legal name of the individual, and the individual does not have a midd d the full legal name of the individual, and the individual does not have a midd d the full legal name of the individual, and the individual does not have a midd d the full legal name of the individual (one context)	ne 💌
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* Last Name: Middle Name: * Date of Birth: * Email: * Business Relationship: I attest that I have entered * Address Line 1: Address Line 2: * City: * State: * ZIP Code:	First Name: Suffix: Select C (Enter your full middle name) mm/dd/yyyy F * SSN: * Phone Number: (000) 000 Select One d the full legal name of the individual, and the individual does not have a midd d the full legal name of the individual, and the individual does not have a midd 00000-0000 Please required	Verify Address Add Clear Add Clear

Exhibit 24. Agents and Managing Employees Page



Step	Action
1	Relationship Disclosure: Does the applicant have any agent(s) and/or managing employee(s)?: Select Yes or No ; if Yes , Managing Relationships displays.
2	Select Edit to edit an existing Managing Relationship to change Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Business Relationship, and Relationship to Another Disclosing Person.
3	Add a Relationship by entering Last Name, First Name, Middle Name, Suffix, Date of Birth, SSN, Business Relationship, and Relationship to Another Disclosing Person. Then select Add.
4	Select Next to continue.

3.21 HOSPITAL ADMITTING PAGE

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

ndicates a required field			Legend
* HOSPITAL ADMITTING PRIVILEGES			
Does the enrolling provider have hospital a	admitting privileges?		
🖲 Yes 💿 No			
Hospitals			?
Add County Hospitals			
select hospitals in other counties	▼	entry, you may then repeat this	process to
* Hospital(s): Available Options		Selected Options	
* Hospital(s): Available Options SELECT SPECIALITY HOSPITAL DURH	د bbA	Selected Options)SPI
* Hospital(s): Available Options SELECT SPECIALTY HOSPITAL DURH DUKE UNIVERSITY HOSPITAL DURHAM REGIONAL HOSPITAL	۲ bbA د llA bbA	Selected Options	OSPI
* Hospital(s): Available Options SELECT SPECIALTY HOSPITAL DURH DUKE UNIVERSITY HOSPITAL DURHAM REGIONAL HOSPITAL	Add > Add All >	Selected Options	DSPI
* Hospital(s): Available Options SELECT SPECIALTY HOSPITAL DURH DUKE UNIVERSITY HOSPITAL DURHAM REGIONAL HOSPITAL	Add > Add All > < Remove	Selected Options	OSPI
* Hospital(s): Available Options SELECT SPECIALTY HOSPITAL DURH DUKE UNIVERSITY HOSPITAL DURHAM REGIONAL HOSPITAL	Add > Add All > < Remove < Remove All	Selected Options	DSPI
* Hospital(s): Available Options SELECT SPECIALTY HOSPITAL DURH DUKE UNIVERSITY HOSPITAL DURHAM REGIONAL HOSPITAL	Add > Add All > < Remove < Remove All	Selected Options	OSPI 4 Add
* Hospital(s): Available Options SELECT SPECIALTY HOSPITAL DURH DUKE UNIVERSITY HOSPITAL DURHAM REGIONAL HOSPITAL	Add > Add All > < Remove < Remove All	Selected Options	OSPI 4 Add

Exhibit 25. Hospital Admitting Page

Step	Action
1	Does the enrolling provider have hospital admitting privileges?: Select Yes or No . Select Yes to add hospital(s).
2	Select the County in which the hospital is located.




Step	Action
3	Available Options: Select the hospital(s) to which the provider has admitting privileges. Note : Multiple hospitals in a County can be selected by holding down the CTRL key and selecting each hospital.
4	Select Add to save the hospital selections.
5	Select Next to continue.

3.22 PHARMACY INFORMATION PAGE

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

3.23 FACILITIES INFORMATION PAGE

The **Facilities Information** page allows providers to specify whether a hospital is a teaching hospital and to enter bed accommodations types.

3.24 METHOD OF CLAIM/ELECTRONIC SUBMISSION PAGE

The **Method of Claim/Electronic Submission** page captures how the provider will be submitting and/or receiving electronic transactions.

3.25 AFFILIATED PROVIDER INFORMATION PAGE

The **Affiliated Provider Information** page captures information on the Organization(s) to which an Individual provider wants to affiliate. Individual providers can select **Yes** or **No** to indicate their participation in CCNC/CA when they affiliate to a CCNC/CA Organization.

Affiliated Provider Information	🖨 AA Helo
* indicates a required field	Legend 👻
* AFFILIATED PROVIDER INFORMATION Do you wish to link or affiliate with another enrolled provider?	
Select Yes if you wish to identify one or more organizations who may bill and may Yes No	be paid for services you have rendered.
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'.	
Crganization Name: Enrollment Effective Date:	
Please select locations of affiliated provider.	
Select box next to the location(s) you wish to affiliate and click 'Add'.	
Location	Do you wish to participate in CCNC/CA under this group?
3	4 5 Add
R Previous	Please be sure to complet

Exhibit 26. Affiliated Provider Information Page





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

3.26 ASSOCIATE BILLING AGENT PAGE

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

3.27 EFT ACCOUNT INFORMATION PAGE

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

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

3.28 PROVIDER SUPPLEMENTAL INFORMATION PAGE

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





Provider Supplemental Information

Enter your work history as a health more than six months, please uplo	n professional for the pa ad documentation clarif	ast 5 years. Work histo fying the gap upon ap	ory prior to 5 years ago is not n plication submission.	eeded. If there is a gap in	your employment o
Add Work History					
* Company Name:			* Job Title:		
* Start Date:	mm/dd/yyyy		* End Date:	mm/dd/yyyy	
EDUCATION					
Enter your highest level of education	on completed.				
Add Education History					
* School Name:			* Degree:		
* Start Date:	mm/dd/yyyy		* Graduate Date:	mm/dd/yyyy	
CURRENT MALPRACTICE INSURANCE COV	ERAGE				
Medical providers should carry pro-	essional liability covera	ide often called malor	actice insurance. This insurance	e covers your exposure to l	iability arising from
Medical providers should carry pro your profession, including allegation	fessional liability covera ns of malpractice. Liabi	ige, often called malpr lity insurance offers e	actice insurance. This insurance ssential financial protection beca	e covers your exposure to I ause a malpractice suit can	iability arising from 1 be brought agains
Medical providers should carry pro your profession, including allegation you at any time after you have see	fessional liability covera ns of malpractice. Liabi en a patient.	ige, often called malpr lity insurance offers e	actice insurance. This insurance ssential financial protection bec	e covers your exposure to I ause a malpractice suit can	iability arising from be brought agains
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Medical providers should carry pro your profession, including allegatio you at any time after you have see Enter your current malpractice insu a copy of the federal tortletter or a * Do you have malpractice insuran O Yes O No	essional liability covera ns of malpractice. Liabi n a patient. rrance coverage. Upon n attestation from the p ce or are you covered u	ige, often called malpr lity insurance offers ex submission of the app practitioner of federal under a federal tort?	actice insurance. This insurance ssential financial protection bec lication, upload a copy of the in tort coverage.	e covers your exposure to I ause a malpractice suit can surance face sheet from th Please be sure	iability arising from be brought against e malpractice carrie
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Exhibit 27. Provider Supplemental Information Page

Step	Action
1	 Work History: Enter your work history as a health professional for the past 5 years. There is not a need to provide any work history prior to the 5-year timeframe. If there is a gap in the Individual provider's work history of 6 months or more, the provider is required to upload written documentation explaining any gaps that occurred in the past 5 years. Company Name: Employer name
	Job Title: Position/job title
	Start Date: Start date of the job title at this company
	 End Date: End date of the job. If you still hold this job title at this company, enter 12/31/9999.
	Note : When entering work history, if the enrolling provider is currently a resident or intern, he/she should enter the details of that residency/internship such as:
	Company Name: Healthcare Facility XYZ
	Job Title: Resident
	Start Date: Date residency/internship began
	End Date: 12/31/9999 if still a resident/intern





Step	Action
2	Education: Enter your Education information.
	School Name: School or institution name
	Degree: Highest degree
	 Start Date: Date started at the school or institution
	 Graduation Date: Date graduated from the school with this degree
3	Current Malpractice Insurance Coverage:
	• Do you have malpractice insurance or are you covered under a federal tort?: Select
	Yes if you have malpractice insurance or are covered under a federal tort.
	 Malpractice Type: Select the type of malpractice coverage
	 Amount: Enter the amount of malpractice coverage
	Effective Date: Effective date of the coverage
	 Expiration Date: Expiration date of the coverage





3.29 EXCLUSION SANCTION INFORMATION PAGE

dicates a r	equired field	L anand
		Legend
XCLUSION	SANCTION INFORMATION	
The que 1002.3.	stions 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
e "An gen boa	agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This may include eral managers, business managers, office managers, administrators; Electronic Funds Transfer (EFT) authorized individuals, Indiv rd members, etc.	managing employees /Idual officers, directo
• All a	upplicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.	
For each clearly in	question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, a dicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this	and/or final dispositio s application.
A. Has alony, or Yes	: the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, p entered into a pre-trial agreement for a felony? ONo	oled no contest to a
Please a	add up to 5 Infraction/Conviction Dates.	
= INF	RACTION/CONVICTION DATES	
O 09/0	Infraction/Conviction Date	
nm 5	/dd/yyyy 🗷	
		2 Add CI
B. Has ny other ertifying rovided, OYes	the applicant, managing employees, owners, or agents ever had disciplinary action taken against any business or professional il state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously four or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or th or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?	cense held in this or id by a licensing, e quality of services
C. Has om Med r profess rivate he uspende ealth ins O Yes	i the applicant, managing employees, owners, or agent sever been denied enrollment, been suspended, excluded, terminated, or icare, Medicaid, or any other government or private health care or health insurance program in any state; or 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 suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health care or health care or health insurance program in any state; or ever been directly or indirectly affiliated with a provider or id, excluded , terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or program in any state?	r involuntarily withdra a corporation, busines ny other government supplier that has bee re or health care or
D. Has orporation filiated	a the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or n, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state; or ever been with a provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state?	or been employed by a directly or indirectly
E. Has Program	the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other m, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?	State or Federal Age
F. Doo ffillated OYes	es the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid; or ever be with a provider or supplier that has uncollected debt owed to Medicare, Medicald, or CHIP? No	en directly or indirect
K G. Has buse of a ⊖Yes	s the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense rela a patient in connection with the delivery of any health care goods or services? No	ted to the neglect or
H. Has hanufact	s the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense rela ure, distribution, prescription, or dispensing of a controlled substance? No	ting to the unlawful
K I. Has duciary O Yes	the applicant, managing employees, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, ember responsibility, or other financial misconduct? No	azzlement, breach of
J. Has arolina's anctione evoked?	the applicant, managing employees, owners, or agent sever been found to have violated federal or state laws, rules, or regulation Medicaid program or any other state's Medicaid program or any publicly funded federal or state health care or health insurance d accordingly; or ever been directly or indirectly affiliated with a provider or supplier that had its Medicare, Medicaid, or CHIP bill	ons governing North program and been ing privileges denied
OYes	• No	
K. Has	It the applicant, managing employees, owners, or agents ever been convicted of an offense against the law other than a minor tra No	affic violation?
OYes		

Exhibit 28. 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 Add 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. If uploading an explanation for an affirmative exclusion sanction response, ensure the letter is signed by the provider, person with infraction, or Office Administrator and that the letter is dated. The letter must be dated within the past six months of the date of this.
	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.
2	Select Add to add an Infraction/Conviction Date.





3.30 REVIEW APPLICATION PAGE

The **Review Application** page allows the ES user to review the application before assigning it to the OA.

indicates a required field	Legend
ELECTRONIC SIGNATURE - EMAIL CONFIRMATION	
 Please confirm that the email address below is correct. If you dont already have one, an Electronic Signature PIN will upon submitting the next page. You will need access to this email address to retrieve/reset your PIN and complete th 	be sent to this address is Online Application.
• If the email below is incorrect, you may now navigate back to the <u>Basic Information page</u> to update it. (Remember to d <u>Information page</u> to store your change.)	lick Next on the <u>Basic</u>
Contact Email:	
REVIEW APPLICATION	
To review your application in Adobe PDF format, click 'Review Application' below. If you have successfully completed all	required information for
your provider enrolment application and are satisfied the information is complete and accurate, you may proceed to the A Electronic Application page by clicking 'Next'.	Attachments/Submit
your provider enrolment application and are satisfied the information is complete and accurate, you may proceed to the A Electronic Application page by clicking 'Next'.	Review Application
Your provider enrolment application and are satisfied the information is complete and accurate, you may proceed to the A Electronic Application page by clicking 'Next'. Assign Application to Office Administrator	Review Application
Your provider enrolment application and are satisfied the information is complete and accurate, you may proceed to the A Electronic Application page by clicking 'Next'. Assign APPLICATION TO OFFICE ADMINISTRATOR When you have deemed the application complete and ready for the Office Administrator (OA) to review and submit the ap Assign Application to OA button.	Review Application ,
Your provider enrolment application and are satisfied the information is complete and accurate, you may proceed to the A Electronic Application page by clicking 'Next'. Assign AppLication to OFFICE ADMINISTRATOR When you have deemed the application complete and ready for the Office Administrator (OA) to review and submit the ap Assign Application to OA button. 3	Review Application , oplication, select the Assign Application to G
Your provider enrollment application and are satisfied the information is complete and accurate, you may proceed to the A Electronic Application page by clicking 'Next'. Assign Application to OFFICE ADMINISTRATOR When you have deemed the application complete and ready for the Office Administrator (OA) to review and submit the ap Assign Application to OA button. Please be sur required fields v	Review Application , opplication, select the Assign Application to (re to complete all with valid content.

Exhibit 29. Review Application Page

Step	Action
1	Confirm the Contact Email listed is correct; if not, use the provided hyperlink to access the Basic Information page to update it.
2	Select Review Application to review the information entered for accuracy. Selecting this button displays a window that allows the ES user to open a PDF file of the application. The ES user can print and review the application for accuracy before assigning it to the OA.
3	Select Assign Application to OA to assign the application to the OA for review and submission, where applicable. When the ES user selects this button, they will be redirected to the Status and Management page. Note : An e-mail will be sent to the OA notifying them that the application is ready to be signed and submitted.

Note: The Assign Application to Office Administrator section displays only when the loggedin user is the ES user.





The **Status and Management** page displays categories of applications. The status of all submitted applications displays on this page as well, allowing the provider to determine if their application is in review, has been abandoned or returned, or has an approved status.

From the **Submitted Applications** section, providers can pay application required fees by selecting the **Pay Now** hyperlink; withdraw a previously submitted application by selecting the **Withdraw** hyperlink; or upload supporting documents, when requested, by selecting the **Upload Documents** hyperlink. Additionally, CSRA uses the **Submitted Applications** section to advise providers of incomplete applications.

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 given an additional 10 days to submit the required information. If the information is received and reviewed and it is still deemed inadequate, the provider will be given an addition 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 within the initial 30 days, the application will be abandoned.

The OA/ES user has access to the notification letters via the Message Center Inbox and via a hyperlink on the **Status and Management** page, to view the notifications.

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

CSRA may return an application and send the OA an Application Incomplete Letter. When the **Returned** hyperlink is selected, the provider will be redirected to the Application Incomplete Letter, which contains details of the incorrect information received. After reviewing the incorrect information indicated in the letter, if the provider agrees that the information is incorrect, the OA should navigate to the **Status and Management** page and withdraw the application. The provider can also respond to the Application Incomplete Letter advising that the information is incorrect and requesting that CSRA withdraw the application. If CSRA withdraws the application, the Application Withdrawn Letter is sent to the Message Center Inbox. Application Withdrawn Letters for initial Enrollment applications will be sent to the OA's e-mail address.

Applications withdrawn by CSRA or the provider will have a "Withdrawn" status in the **Submitted Applications** section. CSRA-withdrawn applications will always be accompanied by an Application Withdrawn Letter. Providers do not receive correspondence when the withdrawal is completed in the Provider Portal.





Status and Management

* indicates a required field



Welcome to Provider Enrollment Status and Management Please choose from the options below to manage your enrollment status.

Below is the status o	of applications you have :	submitted.			
If status is Payment payment. If status is	Pending, we have receiv s Pay Now, your NC Appl	ed initial confirmation from ication Fee payment was n	n Paypoint that your payment was cor not made or failed; click Pay Now to m	nfirmed; it may ake payment.	take up to 48 hours to verify the
If status of the appli hyperlink.	ication is in Payment Pen	ding, Returned, or In Revi	ew, you can upload supporting docum	entation by clic	king the Upload Documents
E RECORD RESULT	s				
NPI/Atypical ID	Name	DBA Name	Application Type	Submit Date	Status
		and the second s	RE-VERIFICATION	10/09/2019	Withdrawn
			MANAGE CHANGE REQUEST	08/29/2019	Withdrawn
			RE-VERIFICATION	01/09/2019	Withdrawn
			ABBREVIATED AFFILIATIONS MANAG	12/20/2018	Manage Change Request Comple
			MANAGE CHANGE REQUEST	10/26/2018	Withdrawn
			MANAGE CHANGE REQUEST	10/09/2017	Manage Change Request Comple
			ENROLLMENT	08/09/2017	Withdraw, Upload Documents - Review
			MANAGE CHANGE REQUEST	04/12/2017	Withdrawn
			MANAGE CHANGE REQUEST	04/11/2017	Approved
			ABBREVIATED METHOD OF CLAIM BI	04/11/2017	Manage Change Request Comple
			ABBREVIATED METHOD OF CLAIM BI	03/07/2017	Manage Change Request Comple
			ABBREVIATED METHOD OF CLAIM BI	01/13/2017	Manage Change Request Comple
			ABBREVIATED METHOD OF CLAIM BI	12/21/2016	Manage Change Request Compl
			MANAGE CHANGE REQUEST	11/09/2016	Manage Change Request Comple
			ABBREVIATED METHOD OF CLAIM BI	11/04/2016	Manage Change Request Comple
			RE-VERIFICATION	10/20/2016	Withdrawn
			ABBREVIATED EFT MANAGE CHANGE	10/17/2016	Manage Change Request Compl
			MANAGE CHANGE REQUEST	08/19/2016	Withdrawn
			RE-VERIFICATION	06/15/2016	Withdrawn
			ENROLLMENT	01/14/2016	Approved
			RE-VERIFICATION	12/07/2015	Withdrawn





	ATA FOUND						
MANAG	E CHANGE REQUEST						
If you NCTra The fo	u are a behavioral health acks Manage Change Re ollowing provider accour click ' Update '.	h provider contracted with equest application, please (nts associated with your N	a Local Management Entity/M ensure your LME/MCO has the CID are active. Please select t	anaged Care Or same updated he account with	ganization (LME/MCO) ar data on file. which you would like to	nd you update your da submit a Manage Char	a in a Ige Requ
- Rr	CORD RESULTS						
Select	NPI/Atypical ID	Name		DBA Name		ZIP Code Begin	Date
0							1
0							,
0							
RE-VEF	RIFICATION						
NO D	ATA FOUND						
MAINT	AIN ELIGIBILITY						
NOD							
FINGER	PRINTING REQUIRED						
NOD							
NO D							
SAVED							
SAVED	APPLICATIONS	the set of the		64. 1 × ×			-
SAVED A Please applic	APPLICATIONS e remember that your a cation will be deleted.	pplication must be submit	ted to the State within 90 day	s of the date it	was created. If not comp	leted within 90 days, t	he incom
SAVED / Please applic	APPLICATIONS e remember that your a cation will be deleted.	application must be submit	ted to the State within 90 day	s of the date it	was created. If not comp	leted within 90 days, t	he incom
SAVED A Please applic = RE Select	APPLICATIONS e remember that your a cation will be deleted. CORD RESULTS NPI/Atypical ID	upplication must be submit Name	ted to the State within 90 day DBA Name	s of the date it	was created. If not comp Application Type	eted within 90 days, t Application Create Date	Last S
SAVED / Please applic - RE Select	APPLICATIONS e remember that your a cation will be deleted. ECORD RESULTS NPI/Atypical ID	application must be submit	ted to the State within 90 day DBA Name	s of the date it	Application Type MANAGE CHANGE REQUEST	Application Create Date 09/14/2021	Last S
SAVED A Please applic Select	APPLICATIONS e remember that your a cation will be deleted. ECORD RESULTS NPI/Atypical ID	upplication must be submit Name	ted to the State within 90 day DBA Name	s of the date it i	Application Type MANAGE CHANGE REQUEST MANAGE CHANGE REQUEST	Application Create 09/14/2021 08/10/2021	Last : 09/14
Please applic Select	APPLICATIONS e remember that your a cation will be deleted. CORD RESULTS NPI/Atypical ID	upplication must be submit	ted to the State within 90 day DBA Name	s of the date it	Application Type MANAGE CHANGE REQUEST MANAGE CHANGE REQUEST MANAGE CHANGE REQUEST	Application Create Date 09/14/2021 08/10/2021 03/24/2021	Last 5 09/14 08/10 07/21
Please applie Select	APPLICATIONS e remember that your a cation will be deleted. CORD RESULTS NPI/Atypical ID	application must be submit Name	ted to the State within 90 day DBA Name	s of the date it ZIP Code	Application Type MANAGE CHANGE REQUEST MANAGE CHANGE REQUEST MANAGE CHANGE REQUEST MANAGE CHANGE REQUEST	Application Create Date 09/14/2021 08/10/2021 03/24/2021 07/21/2021	Last 5 09/14 08/10 07/21 10/20
SAVED / Please applic Select	APPLICATIONS e remember that your a cation will be deleted. CORD RESULTS NPI/Atypical TD	upplication must be submit	ted to the State within 90 day DBA Name	s of the date it i	Application Type MANAGE CHANGE REQUEST	Application Create Date 09/14/2021 08/10/2021 03/24/2021 07/21/2021 06/18/2021	Last 5 09/14, 08/10, 07/21, 10/20, 10/13,
SAVED A Please applic Select O O O O O O O	APPLICATIONS e remember that your a cation will be deleted. CORD RESULTS NPI/Atypical ID	upplication must be submit	ted to the State within 90 day DBA Name	s of the date it ZIP Code	Application Type MANAGE CHANGE REQUEST	Application Create Date 09/14/2021 08/10/2021 03/24/2021 07/21/2021 06/18/2021 10/20/2021	Last S 09/14, 08/10, 07/21, 10/20, 10/13, 10/20,

Exhibit 30. Status and Management Page





Step	Action
Step 1	 Action Submitted Applications: Allows the ES user to view the status of a submitted provider enrollment application. Abandoned: Application was waiting for additional documentation from the provider, but it was not received within 30 days of the notification. The provider will need to submit a new application. In Review: Application is being reviewed by CSRA or State. Returned: Application was returned to the provider needing additional documentation from the provider. Denied: The provider's participation in the program has been denied. Approved: The provider's participation in the program has been approved. Withdrawn: The provider has withdrawn their application. MCR Comp (Manage Change Request Complete): A change was requested that does not require review; therefore, this change was instantly completed. ME Comp (Maintain Eligibility Complete): The provider's Maintain Eligibility does not require review; therefore, this request was instantly completed. Pymt Pend: (Payment Pending): Records indicate that the provider has made a payment at PayPoint. It may take up to 48 hours to verify a payment. Pay Now: The provider can select the Pay Now link to make a payment on the PayPoint website. It may take up to 48 hours to verify a payment. Note: The ES, OA, and all Managing Employee and Owner users can view the submitted application via the Pay Now and Upload Documents hyperlinks (if applicable) in the Submitted Applications section.
	statuses: In Review, Returned, and Payment Pending. Selecting this hyperlink takes the ES user to the Upload Documents page.
2	Re-enroll: Allows the ES user to re-enroll a terminated provider enrollment account.
3	Manage Change Request: Allows the ES user to submit an MCR to an active provider enrollment account. The ES user may need to update information on the provider record such as EFT, taxonomy, address, affiliations, licensure, or change from an OOS/OPR Lite to a fully enrolled provider. These changes would require an MCR.
4	Re-verification: Allows the ES user to submit a required Re-verification application for a provider enrollment account.
5	Maintain Eligibility: Allows the ES user to submit a required Maintain Eligibility application for a provider enrollment account.
6	Saved Applications: Allows the ES user to resume a saved provider enrollment application.





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4.0 Manage Change Request

Once a provider's enrollment application has been approved, the provider can make updates to the record by completing an MCR.

Note: For additional information on converting an OOS/OPR Lite provider to a Full provider using an MCR, please refer to the Participant User Guides *PRV 595 Out-of-State Provider Enrollment* or *PRV 596 OPR Provider Enrollment*.

4.1 PROVIDER PORTAL HOME PAGE

CITRACKS										-
Provider Portal	Eligibility	Prior Approval	Claims	Referral	Code Search	Enrollment	Administration	Trading Partner	Payment	Consent For
Message Center for										Subso
		Announce	ment	5					More Annou	ncements
12.9		Date: Mar 29 Stay on top of 1 The best way to you are not alrea Communications newsletter, but in	, 2018 1 NCTracks stay on top ady receivin " on the <u>Pr</u> mportant t	- sign up fe o of updates og the news ovider Commission ime-sensitiv	AM Atter or the newslett to NCTracks is t etter, you can s munications web e messages sen	ntion: All Pro ter to subscribe to ubscribe by clio page. Signing t via email.	the NCTracks Com king on the link ur up will ensure that	munications and Up nder the heading "Si t you receive not on	<i>dates</i> newsle ign Up for NC ly the regular	tter. If Tracks r
		WELCOM	E	OFFICE AD	MINISTRATORS	ENROLL	MENT			
AN		Provid Trainii	er ng	U Admin	ser istration	Status Manage	and ement			
Inbox Provider Status	Massaga						Date	All Mess	ages (26)	
Provider Status	Message						Date	<u>All Mess</u>	ages (26)	

Exhibit 31. Provider Portal Home Page

Step	Action
1	From the Provider Portal Home page, select Status and Management.

The **Status and Management** page displays. To begin an MCR application, scroll down to the **Manage Change Request** section.





MANAGE If you a NCTrack The follo Request	MANAGE CHANGE REQUEST ? If you are a behavioral health provider contracted with a Local Management Entity/Managed Care Organization (LME/MCO) and you update your data in a NCTracks Manage Change Request application, please ensure your LME/MCO has the same updated data on file. The following provider accounts associated with your NCID are active. Please select the account with which you would like to submit a Manage Change Request, then click 'Update'. RECORD RESULTS								
Select	NPI/Atypical ID	Name	DBA Name	ZIP Code	Begin Date	Status			
0	0100-0100	CONTRACTOR OF STREET,		27502-1216	01/01/2015	Active			
0	D. D	CONTRACTOR OF STREET	10.011-00000000000000000000000000000000	27502-1216	01/01/2015	Active			
1 0	1154308308	ABARTA - APPENDING - D	- ALCONTRACTOR - IN - MARKED	28403-6062	02/01/2005	Active			
0	DIREMENTATION INTO A CONTRACT OF THE OWNER OF T			27502-1216	01/01/2015	Active			
0	DEFENDED		THE COMPLEX WELL CONTRACTORS	27502-1216	01/01/2015	Active			
	2 Update								

Exhibit 32. Status and Management Page: Manage Change Request Section

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

4.2 HEALTH / BENEFIT PLAN SELECTION PAGE

The **Health / Benefit Plan Selection** page allows providers to manage their participation in the NC DHHS health and benefit plans. Providers can view their status, reinstate participation, add new health and benefit plans, and terminate participation in health and benefit plans.

Note: A \$100 NC Application Fee is required for Individual providers when applying for Medicaid. For In-State, Border, OOS Full Organizations, and Atypical Organizations, a \$100 NC Application Fee is required.

4.2.1 Current Status

lealth / Benefit Plan	Selection			🚔 🗚 Help					
indicates a required field									
What are the qualification	ns and requirements fo	r the NC DHHS Health Plans?							
See Provider Permission	Matrix.								
CURRENT STATUS									
E CURRENT HEALTH/BENEF	IT PLAN STATUS		0						
Health Plan	Health Plan Status	Benefit Plan	4 Benefit Plan Status	Effective Date					
TITLE NCXIX	ACTIVE			03/01/2013					
TITLE NCXXI	TERMINATED			03/13/2013					
PUBLIC HEALTH	ACTIVE			03/01/2013					
		Infant Toddler	ACTIVE	03/14/2013					
		Sidde Cell	ACTIVE	03/14/2013					
		Early Hearing Detection and Intervention Program	ACTIVE	03/14/2013					
		AIDS HIV Drug Assistance Program	ACTIVE	03/14/2013					
RURAL HEALTH	ACTIVE			03/01/2013					
		Community Care of NC UP	ACTIVE	03/01/2013					
		Healthnet	ACTIVE	03/01/2013					

Exhibit 33. Health / Benefit Plan Selection Page: Current Status Section





Step	Action
1	Health Plan identifies the NC DHHS health plans:
	Title NCXIX – Medicaid
	Public Health
	Rural Health
2	Health Plan Status – The provider's current status in the health plan:
	 Active – The provider is currently active.
	 Terminated – The provider is currently terminated (not active).
	 New – The provider can add this health plan.
	Hover over the field to display additional information.
3	Benefit Plan – If applicable, benefit plans display.
4	Benefit Plan Status – If applicable, the status of the provider's participation in the benefit
	plans displays:
	 Active – The provider is currently active.
	 Terminated – The provider is currently terminated (not active).
5	Effective Date – This is the effective date of the provider's status. In this example, this
	provider has been active in Title NCXIX since 3/1/2013 and has been terminated in NCXXI
	since 3/13/2013.

Note: If an OPR Lite provider upgrades to a fully enrolled provider, they will then have the option to participate in all health plans.

4.2.2 Active Medicaid Providers

In the **Active Medicaid Providers** section, the ES user can indicate whether a provider or organization will be providing behavioral health services.

	ACTIVE MEDICAID PROVIDERS
2	* Will you only be serving 0-3 population for behavioral health services?
Ч	Yes No
	0103 0110

Exhibit 34. Health / Benefit Plan Selection Page: Active Medicaid Providers Section

Step	Action
1	Select Yes if the provider will only be serving the 0-3 Medicaid population for behavioral health services. Select No if the provider submits all claims to their Managed Care Organization (MCO).





4.2.3 Type of Update

In the Type of Update section, the ES user can select the type of update they want to make.

TYPE OF UPDATE	?
If you choose to end-date (remove) one or more coverage types, you will not have the option to add any until you start the re-enrollment or manage change request process again. Adding and removing coverage types must be completed with separate transactions. Note: If applicable, SA Information may be updated alone, or with the <i>Add/Reinstate Health Plan Option(s)</i> choice.	
A Would you like to remove TLAdd/Reinstate Health Plan(s)	
● Yes ◎ No	
TITLE NCXIX End-date Info	?
3 * End Date: mm/dd/yyyy 🔣	
4 * Reason for ending	
coverage:	
Comments:	
 ★ Would you like to remove TITLE NCXXI from your active Health Plans? ⑦ Yes ⑦ No 	
 ★ Would you like to remove PUBLIC HEALTH from your active Health Plans? ⊘ Yes ⊘ No 	
* Would you like to remove RURAL HEALTH from your active Health Plans?	

Exhibit 35. Health / Benefit Plan Selection Page: Type of Update Section

Step	Action
1	 Update Type: Select one of the following: No Updates: Select if you do not wish to make any changes. Note: In MCR applications, the default is set to 'No Updates'. Remove Health/Benefit Plan(s): Select to terminate provider's participation in one or more health/benefit plans. Add/Reinstate Health Plan Option(s): Select to add or reinstate terminated health/benefit plans.
2	Select Yes or No to each health plan "Would you like to remove" question.
3	End Date: When Yes is selected, the ES user must enter the effective date of the termination in the End Date field.
4	Reason for ending coverage: When Yes is selected, the ES user must select a reason for the termination.



North Carolina Medicaid Management Information System (NCMMIS)



4.3 ADDRESSES PAGE

The **Addresses** page displays all addresses on file for the provider. The ES user can edit, end-date, or add addresses.

4.3.1 Reinstate an End-Dated Address

If one of a provider's addresses has been end-dated, it is not necessary to add the address; the ES user can reinstate the address.

Service Locations							
SERVICE LOCATION 2 - 1803	SERVICE LOCATION 2 - 1803 CHAPEL HILL RD						
Service Location Name							
Office Phone #:		Office Fax #:					
Address							
Address Line 1:							
Address Line 2:							
City:	DURHAM						
State:	NORTH CAROLINA						
ZIP Code:	27707-1149	County:	DURHAM				
Begin Date:		2 End Date:					
Servicing Counties	DURHAM			3			
				Edit			

Exhibit 36. Addresses Page: Reinstate an End-Dated Address #1

Step	Action
1	Expand the desired Service Location.
2	End Date: Displays the End Date on file for this address.
3	Select Edit.





After updating the fields, please click the Save button. Service Location Name * Office Phone #: (@19) 555-8500 ext. Address Address Address Line 1: Address Line 2: * City: DURHAM State: NORTH CAROLINA * City: DURHAM State: NORTH CAROLINA * ZIP Code: 27707-1149 Begin Date: End Date @ Re-instate 1 * New Begin Date: Imm/dd/yyy Servicing Counties 2 Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept County County ALAMANCE ALEXANDER ALAMANCE AVERY				CHAPEL HILL RD	SERVICE LOCATION 2 - 1803
Service Location Name * Office Phone #: (919) 555-8500 ext. Office Fax #: (000) 000-0000 Address Address Line 1:				e click the Save button.	After updating the fields, pleas
Address Line 1: Address Line 2: * City: DURHAM State: NORTH CAROLINA * ZIP Code: 27707-1149 Begin Date: Re-instate 1 * New Begin Date: mm/dd/yyy 2 Servicing Counties Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees. Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees. County County ALEXANDER ALEXANDER ASHE AVERY BEAUFORT BEAUFORT BEAUFORT BEAUFORT BEAUFORT COUNTY County BEAUFORT		000-0000	Office Fax #:	(919) 555-8500 ext.	Service Location Name * Office Phone #:
State: NORTH CAROLINA ** ZIP Code: 27707-1149 Begin Date: End Date Image: Re-instate for the control of				DURHAM	Address Line 1: Address Line 2: * City:
Re-instate Re-instate ** New Begin Date: mm/dd/yyyy Servicing Counties Verify / Servicing Counties Verify / Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees. County County ALAMANCE ALEXANDER ASHE AVERY			County:	NORTH CAROLINA	State: * ZIP Code: Begin Date:
Servicing Counties Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees. County County County County County ALAMANCE ALEXANDER ALLEGHANY ANSON ASHE AVERY BEAUFORT BERTIE	Address	Verify Ad		Re-instate 1 mm/dd/yyy	♥ Wew Begin Date:
County County County County I ALAMANCE I ALEXANDER I ALLEGHANY I ANSON I ASHE I AVERY I BEAUFORT I BERTIE) your practice will accept	the contiguous counties for	n addition to your county, please selec	Servicing Counties Note to CCNC/CA providers: 1 CCNC/CA enrollees.
ALAMANCE ALEXANDER ALLEGHANY ANSON ASHE AVERY BEAUFORT BERTIE	<u>^</u>	County	County	County	County
ASHE AVERY BEAUFORT BERTIE	=	ANSON	ALLEGHANY	ALEXANDER	ALAMANCE
		BERTIE	BEAUFORT	AVERY	ASHE
BLADEN BRUNSWICK BUNCOMBE BURKE		BURKE	BUNCOMBE	BRUNSWICK	BLADEN
CABARRUS CALDWELL CAMDEN CARTERET		CARTERET	CAMDEN	CALDWELL	CABARRUS
CASWELL CATAWBA CHATHAM CHEROKEE		CHEROKEE	CHATHAM	CATAWBA	CASWELL
CHOWAN CLAY CLEVELAND COLUMBUS		COLUMBUS	CLEVELAND	CLAY	CHOWAN
CRAVEN CUMBERLAND CURRITUCK DARE	3	DARE	CURRITUCK	CUMBERLAND	CRAVEN

Exhibit 37. Addresses Page: Reinstate an End-Dated Address #2

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





4.3.2 End-Date an Active Address

If one of a provider's active addresses will be closed, the ES user can end-date the address.

	e enere dave decom					
Service Location Name * Office Phone #:	(919) 555-1212 ext.	Office Fax #:	(000) 000-0000			
Address						
Address Line 1:						
Address Line 2:						
* City:	DURHAM					
State:	NORTH CAROLINA					
* ZIP Code:	27701-3719	County: D	ourham			
Begin Date:	03/01/2013	U 🗹 E	nd Date It			
Verify Address Servicing Counties Note to CCNC/CA providers: In addition to your county, please select the contiguous counties for which your practice will accept CCNC/CA enrollees.						
County	County	County	County	*		
ALAMANCE	ALEXANDER	ALLEGHANY	ANSON	=		
ASHE	AVERY	BEAUFORT	BERTIE			
BLADEN	BRUNSWICK	BUNCOMBE	BURKE			
CABARRUS	CALDWELL	CAMDEN	CARTERET			
	CATAWBA	CHATHAM	CHEROKEE			
CASWELL	_					
CASWELL CHOWAN	CLAY					

Exhibit 38. Addresses Page: End-Date an Active Address

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





4.4 TAXONOMY CLASSIFICATION PAGE

Taxonomy Classification		
* Indicates a required field		Legend 🔻
- SERVICE LOCATIONS	Level See	East Shalus
Select	Location	Complete
e		V Complete
To complete information for each s	ervice location, select the appropriate location then click the "Edit Location" button.	
		Edit Location
Taxonomy Classification		
SCHOOL BASED HEALTH CENTER		?
* Is your organization a School E	Based Health Center (SBHC)?	
🗢 Yes 👻 No		
		+
Please select the Taxonomy Class to the National Plan & Provider En If a submitted taxonomy has not b	ification(s) under which you will be conducting business with NCTracks. All taxonomies select umeration System (NPPES) when you enumerated this NPI. een reported to NPPES, please report it within the next 30 days.	ed should have been reported
TYPE, CLASSIFICATION AND AREA OF SI	PECIALIZATION	?
Please select a Provider Type, Cl rendering. You may enter up to 15	assification and Area of Specialization from the following drop-down lists that best describe the 5 Taxonomy Classifications.	e services you will be
+ TAXONOMY CLASSIFICATION - 1	193200000X - Multi-Specialty END DATED	
TAXONOMY CLASSIFICATION - 2	251B00000X - Case Management	
TAXONOMY CLASSIFICATION - 2	282N00000X - General Acute Care Hospital END DATED	
Provider Type:	HOSPITALS	
Classification:	General Acute Care Hospital	
Area of Specialization:	None	
2 Begin Date:	03/14/2013 End Date: 03/15/2013 3 Status:	ENDDATED
Reason Code:	Voluntary Termination. No lon	4
		Edit

Exhibit 39. Taxonomy Classification Page: Edit Taxonomy

Step	Action
1	Expand the desired taxonomy.
2	Begin Date: Begin date of the current status.
3	Status: Current status of the provider for this taxonomy:
	 Active – The provider is currently active.
	 Terminated – The provider is currently terminated (not active).
	 Suspended – The provider is currently suspended.
4	Select Edit.





4.4.1 End-Date a Taxonomy

If the provider wants to terminate participation in a taxonomy, the ES user can end-date the taxonomy.

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

- TAXONOMY CLASSIFICATION -	282N00000X - GENERAL ACUTE	CARE HOSPITAL			
After updating the fields, please	click the Save button.				
Provider Type:	HOSPITALS				
Classification:	General Acute Care Hospital				
Area of Specialization:	None				
Regin Date:	02/14/2012	Stat			
	End Date It	Stat	JS. ACTIVE		
2 * End Date:	mmlddhaan				
* Elid Date;					
Reason Code:	Select One	÷			4
					Save
+ TAXONOMY CLASSIFICATION -	3336C0003X - COMMUNITY/RET	AIL PHARMACY			
Once all taxonomies have been add	led, click the " Save Location " butt	ion to save.			
				Save	Location
					5*
<pre>« Previous</pre>			r	Please be sure to complete all required fields with valid content.	Next »
				Save Draft Cancel Enro	ollment

Exhibit 40. Taxonomy Classification Page: End-Date a Taxonomy

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

4.4.2 Reinstate an End-Dated Taxonomy

If one of a provider's taxonomy codes has been end-dated, it is not necessary to add the taxonomy; the ES user can reinstate the taxonomy.

TAXONOMY CLASSIFICATION - 2	51B00000X - CASE MANAGEMENT		
After updating the fields, please	click the Save button.		
Provider Type:	AGENCIES		
Classification:	Case Management		
Area of Specialization:	None		
Begin Date:	03/13/2013	Status:	ENDDATED
1	Re-instate		
2 * New Begin Date:	03/18/2013		3
			Save

Exhibit 41. Taxonomy Classification Page: Reinstate an End-Dated Taxonomy





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

4.5 COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS PAGE

If the provider is active in CCNC/CA, the **Community Care of North Carolina/Carolina ACCESS** page displays the provider's CCNC/CA Begin Date and CCNC/CA Contact Person details. The provider can edit their CCNC/CA Contact Person Information or terminate their participation as a CCNC/CA PCP.

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

Note: If the provider is eligible to be a CCNC/CA PCP and is not currently active in CCNC/CA, this page displays exactly as it does in enrollment. See <u>Section 3.0, New Enrollment –</u> <u>Enrollment Specialist</u>.

Community Care of Nort	h Carolina/Carolina ACCES	S		🚔 A A Help
* indicates a required field				Legend 🔻
Select	Locatio	20		Form Status
				Complete
To complete information for each s	service location, select the appropriate	location then dick the "Edit Locatio	n" button	
To complete information for each a	service location, select the appropriate		i buccon.	
				Edit Location
Community Care of North Care	olina/Carolina ACCESS			
To complete information for this lo	ocation, fill out this form section then cli	ck 'Save Location' in lower right.		
	,			2
COMMUNITY CARE OF NORTH CAROLI	NA/CAROLINA ACCESS			
As a Medicaid Provider, you are e	ligible to enroll as a CCNC/CA Provider	if one of your taxonomy classification	ons is on the <u>CCNC</u>	/CA Eligible Provider Types
1 - CCNC/CA CONTACT PERSON				?
* Last Name:		* First Name:		
Middle Name:	,	Suffix:	Select One	▼
* Office Phone #:	evt	Other Phone #:	(000) 000-0000	ovt
Office Fax #:	(000) 000-0000	* Contact Email:	(000) 000 0000	
onice rax #.	(000) 000-0000	- Contact Enfant		1
2 CCNC/CA Begin Date:	04/01/2013	3 🗉	End Date It	
				Save Location
				• *
(I Previous			Please t	e sure to complete all Next 33

Exhibit 42. Community Care of North Carolina/Carolina ACCESS Page

Step	Action
1	CCNC/CA Contact Person: Contact information on file. The applicant can edit any of these fields.
2	CCNC/CA Begin Date: Provider's begin date as a CCNC/CA PCP.





Step	Action
3	Select the End Date It checkbox if provider wants to terminate their CCNC/CA participation.
4	Select Next to continue.

4.6 EFT ACCOUNT INFORMATION PAGE

ndicates a required field		Legend
CURRENT FINANCIAL INSTITUTION ACCO	UNT INFORMATION	
Financial Institution Name:		Account Number: *********
JPDATE FINANCIAL INSTITUTION INFORM	MATION	
* Do you wish to update your Elect	tronic Funds Transfer Fina	ancial Institution information?
CORE website for more information	n (CAQH.org).	sociate your payments with the electronic remittance advice (ERA). You may also visit the CAQH
* Routing Number:		
* Account Number:		* Account Number Confirmation:
* Account Type:	Select One 🗸	
* Financial Institution Name:		
Financial Institution Address		
Address Line 1:		
Address Life 2.		
* City.		
# State.		3
♣ ZIP Code.		Varify Add
		verny Add

Exhibit 43. EFT Account Information Page

Step	Action
1	Current Financial Institution Account Information: Your Financial Institution Name and the last four digits of your Account Number are displayed "as is" from your provider file.
2	Update Financial Institution Information: Do you wish to update your Electronic Funds Transfer Financial Institution information?: Select Yes if you want to update your EFT information. Note : Selecting Yes will expand the section to present fields for the financial institution account information.
3	Complete all required fields marked with an asterisk for the financial institution account information.
4	Select Next to continue.

NOTES:







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5.0 Re-enrollment Application

5.1 STATUS AND MANAGEMENT PAGE



Exhibit 44. Provider Portal Home Page

Step	Action
1	From the Provider Portal Home page, select Status and Management.

The **Status and Management** page displays. To begin a Re-enrollment application, scroll down to the **Re-enroll** section.

RE-ENROLL					?	
The following provider accounts associated with your NCID have been terminated. Please select the account with which you would like to re-enroll, then click 'Submit'.						
E RECORD R	ESULTS					
Select	NPI/Atypical ID	Name	DBA Name	ZIP Code	Termination Date	
1 0				27502-1216	05/13/2015	
					2 Re-Enroll	
					+	

Exhibit 45. Status and Management Page: Re-enroll Section

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





The **Organization/Individual Basic Information** page displays, allowing the ES user to begin the application. The pages look similar to the Enrollment and MCR application pages. See the exhibits in <u>Section 3.0, New Enrollment – Enrollment Specialist</u> and <u>Section 4.0, Manage</u> <u>Change Request</u>. The only difference is that all health plans, taxonomy codes, services, etc. will be end-dated. These will need to be reinstated as desired.

For Individual providers, a \$100 NC Application Fee is required when applying for Medicaid. For Organizations and Atypical Organizations, a \$100 NC Application Fee is required when applying for Medicaid and there is no active provider with the provider's tax ID.

NOTES:





6.0 Re-verification Application

									—
Provider Portal Eligibility	Prior Approval	Claims	Referral	Code Search	Enroliment	Administration	Trading Partner	Payment	Consent For
Message Center for									Subsc
	Announce	ments						More Annou	ncements
	Date: Mar 29,	, 2018 1	2:00:00 A	M Atten	ition: All Pro	oviders			
1201	The best way to a you are not alrea Communications' newsletter, but in	stay on top dy receivir ' on the <u>Pr</u> nportant ti	o of updates og the newsle ovider Comm me-sensitive	to NCTracks is t etter, you can s <u>nunications web</u> messages sent	to subscribe to ubscribe by clic <u>page</u> . Signing t via email.	the NCTracks Com king on the link ur up will ensure that	munications and Up ider the heading "Si t you receive not on	dates newsle gn Up for NC ly the regula	tter, If Tracks
	WELCOM		OFFICE AD	MINISTRATORS	ENROLL	MENT			
AK	Provid Trainir	er ng	U: Admini	ser stration	Status Manage	and 1 ement			
				1					
							All Mess	ages (26)	
Provider Status Message	i					Date			

Exhibit 46. Provider Portal Home Page

Step	Action
1	From the Provider Portal Home page, select Status and Management.

The **Status and Management** page displays. To begin a Re-verification application, scroll down to the **Re-verification** section.

		ed, then click 'Submit'.	which you would like to proce	The following						
			record with which you would like to proceed, then click 'Submit'.							
			RESULTS	- RECORD						
ZIP Code Due Date	DBA Name	Name	NPI/Atypical ID	Select						
27502-1216 05/30/2015	The second secon	Barren	- Contract of the second second second	0						
27502-1216 05/30/2	12.5 - 1888 - 102108	COLUMN COURSE								

Exhibit 47. Status and Management Page: Re-verification Section

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





6.1 RE-VERIFICATION APPLICATION – INDIVIDUAL/ORGANIZATION PROVIDER PAGE

The **Re-Verification Application – Individual** or **Re-Verification Application – Organization** page displays specific identifying information about the provider as an Individual or Organization provider. This information must match what is reported on the provider's income tax return.

If you have any questions or need further information, please feel free to call the NCTracks Operations Contact Center at 800-688-6696.





				Lobolid
DENTIFYING INFORMATION				
* Last Name:		* First Name:		
Middle Name:		Suffix:	Select One 🗸	
W Data of Birth	(Enter your full middle name)	# CCN		
A Date of Birth.		* 35N.	000000000	
* Gender:	Select One V	* NP1:	000000000	
* Email:	full logal name, and I do not have a	niddlo namo		
	run legal hanne, and i do hot have a			
MPLOYER IDENTIFICATION NUMBER	(EIN)			
Will your income be reported t	o an EIN?			
Ves () No				
* EIN:	00-000000			
* DBA Name:				
* Years Doing Business Under				
inis name:				
endering/Attending Only Provi	DER			
Are you a Rendering/Attending	Only provider?			
WNERSHIP INFORMATION				
WNERSHIP INFORMATION * Business Type:	Select One 🗸			
WNERSHIP INFORMATION * Business Type:	Select One v			
WWNERSHIP INFORMATION * Business Type:	Select One v			
WWNERSHIP INFORMATION * Business Type: IFFICE Administrator (Authorize	Select One v			
WNERSHIP INFORMATION * Business Type: IFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below.	Select One v D INDIVIDUAL)	s on behalf of applying provider. T	his role currently belong	s to the person
WMERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID):	Select One	s on behalf of applying provider. T	his role currently belong	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name:	Select One D INDIVIDUAL) Select One	s on behalf of applying provider. T * First Name:	his role currently belong	s to the person
WNERSHIP INFORMATION * Business Type: UFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name:	Select One Information or make business decision Select One	s on behalf of applying provider. T * First Name: Suffix:	his role currently belong	s to the person
WNERSHIP INFORMATION * Business Type: HFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name:	Select One D INDIVIDUAL) Information or make business decision Select One (Enter your full middle name)	s on behalf of applying provider. T * First Name: Suffix:	his role currently belong	s to the person
WNERSHIP INFORMATION * Business Type: HFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email:	Select One D INDIVIDUAL) information or make business decision Select One (Enter your full middle name)	s on behalf of applying provider. T * First Name: Suffix: * SSN:	his role currently belong	s to the person
WNERSHIP INFORMATION * Business Type: HFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email:	Select One D INDIVIDUAL) Information or make business decision Select One (Enter your full middle name)	s on behalf of applying provider. T * First Name: Suffix: * SSN:	his role currently belong	s to the person
WNERSHIP INFORMATION * Business Type: UFFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #:	Select One D INDIVIDUAL) information or make business decision Select One (Enter your full middle name) (000) 000-0000 ext.	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #:	his role currently belong Select One (000) 000-0000	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered	Select One D INDIVIDUAL) Information or make business decision Select One (Enter your full middle name) (000) 000-0000 ext. the full legal name of the individual, a	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a	his role currently belong Select One (000) 000-0000 middle name.	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID. (NCID); * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered	Select One D INDIVIDUAL) information or make business decision (Enter your full middle name) (000) 000-0000 ext. the full legal name of the individual, a	s on behalf of applying provider. T	his role currently belong Select One v (000) 000-0000 middle name.	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered FFECTIVE DATE REQUESTED	Select One D INDIVIDUAL) information or make business decision Select One -· (Enter your full middle name) (000) 000-0000 ext. (000) 100-0000 ext.	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a	his role currently belong Select One (000) 000-0000 middle name.	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Contact Email: * Office Phone #: 1 attest that I have entered FFECTIVE DATE REQUESTED The effective date is the earlies to the date that a complete Pro	Select One D INDIVIDUAL) information or make business decision Select One (Enter your full middle name) (D000) 000-0000 ext. (0000) 000-0000 ext. the full legal name of the individual, a t date a provider may begin billing for vider Enrollment Packet is received ar	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a services. The effective date of et id may not precede, as applicable,	his role currently belong Select One v (000) 000-0000 middle name. nrollment may not be mo	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: 1 attest that I have entered FFECTIVE DATE REQUESTED The effective date is the earlies to the date that a complete Pro current date of your letter of entered	Select One D INDIVIDUAL) information or make business decision (Enter your full middle name) (000) 000-0000 ext. the full legal name of the individual, a t date a provider may begin billing for vider Enrollment Packet is received ar dorsement.	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a services. The effective date of end id may not precede, as applicable,	his role currently belong Select One v (000) 000-0000 middle name. arollment may not be mo	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: I attest that I have entered FFECTIVE DATE REQUESTED The effective date is the earlies to the date that a complete Pro current date of your letter of er Note: CCNC/CA participation eff	Select One D INDIVIDUAL) Information or make business decision (Enter your full middle name) (000) 000-0000 ext. the full legal name of the individual, a the full legal name of the individual, a t date a provider may begin billing for vider Enrollment Packet is received at dorsement. ective date may not be retroactively	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a services. The effective date of end id may not precede, as applicable, requested.	his role currently belong Select One v (000) 000-0000 middle name.	s to the person
WNERSHIP INFORMATION * Business Type: FFICE ADMINISTRATOR (AUTHORIZE Individual authorized to receive populated below. * User ID (NCID): * Last Name: Middle Name: * Contact Email: * Office Phone #: 1 attest that I have entered FFECTIVE DATE REQUESTED The effective date is the earliest to the date that a complete Pro current date of your letter of er Note: CCNC/CA participation eff * Effective Date:		s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a services. The effective date of end id may not precede, as applicable, requested.	his role currently belong Select One v (000) 000-0000 middle name.	s to the person
WNERSHIP INFORMATION		s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a services. The effective date of end id may not precede, as applicable, requested.	his role currently belong Select One v (000) 000-0000 middle name. nrollment may not be mo, the current date of you ce the application is sub	s to the person
WNERSHIP INFORMATION	Select One D INDIVIDUAL) Information or make business decision Select One (Enter your full middle name) (000) 000-0000 ext. (000) 000-0000 ext. (date a provider may begin billing for vider Enrollment Packet is received at dorsement. ective date may not be retroactively mm/dd/yyyy Effective Date is correct and underst	s on behalf of applying provider. T * First Name: Suffix: * SSN: Office Fax #: nd the individual does not have a services. The effective date of end id may not precede, as applicable, requested.	his role currently belong Select One v (000) 000-0000 middle name. nrollment may not be mo, the current date of you ce the application is sub	s to the person

Exhibit 48. Re-Verification Application – Individual Provider Page





dicates a required field				Legend
If you need to undete the Oreaniz	alten Nama mitarit daeramentation th	ask choses morel of a local manual channes	to / CDA sile feer at 655, 710	1665 or hu amail at
NCTracksorevider Binctracks.com	ation Name, submit documentation th	sac snows proof or a legal name change	to CSRA wai lax at 633-716	-1963 or by enall at
Organization Name:				
EIN:		NPI/Atypical Provider ID:		
Email:		Month of Fiscal Year End:	December 👻	
				1
NUMB RUSINESS AS (DRA)				
Do you operate under a trade or Yes O No	company name?			
DBA Information				
# DBA Name:	40			
 tears Doing Business Under This Name: 	18			
WWERSHIP INFORMATION				
* Business Type:	CORPORATION	Y		
REDISTERING WITH NC SECRETARY OF	STATE			
Are you required by law to register	with NC Secretary of State? Yes			
Secretary of State ID #:				
OFFICE ADMINISTRATOR (AUTHORIZED	INDIVIDUAL)			
Individual authorized to receive in	formation or make business decisions	on behalf of applying provider. This role	currently belongs to the pe	rson populated below
. User ID (NCID):				
* Last Name:		* First Name:		
Middle Name:	(Enter your full middle name)	Suffix:	- Select One - +	
* Contact Email	fearing from the monthly	SSN:	And the second sec	
* Office Phone #:	ext.	Office Fax #:	(000) 000-0000	
Is this contact person an Owner Owner Managing Employe	or Managing Employee? e			
				Hest

Exhibit 49. Re-Verification Application – Organization Page

Step	Action
1	Select Next if all information is correct.

6.2 RE-VERIFICATION APPLICATION – TERMS AND CONDITIONS PAGE

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





Re-Verification Application - Terms and Conditions	
* indicates a required field	Legend 🔻
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDER ADMINISTRATIVE PARTICIPATION AGRE 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 the above identified provider, hereinafter referred to as the "Provider."	EMENT
2. Agreement Document The Agreement Documents shall consist of this Agreement, any addendum, and the Provider's application, incorporated herein by reference modifications shall be made to the terms of this Agreement unless through a written amendment executed by both parties. In the event of the terms of this Agreement and any of its addenda, the terms of this Agreement shall control.	e. No alterations or f any conflict between
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 lagreement, venue shall be proper only in Wake County, North Carolina. This Agreement shall not be construed as waiving any immunity to including, without limitation, sovereign immunity, which may be available to the Department.	awsuit involving this suit or liability
The Provider agrees to operate and provide services in accordance with all federal and state laws, regulations and rules, and all policies, p - implementation-undates, and bulletins oublished by the Department, its Divisions and/or its fiscal-agent in effect at the time the service is a	rovider manuals, condeced, which are
Attestation Statement	
* ATTESTATION I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I hav knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or rep	e not herein resentation.
Image: Constraint of the state of	ind content. Next »

Exhibit 50. Re-Verification Application – Terms and Conditions Page





6.2 OWNERSHIP INFORMATION PAGE

The **Ownership Information** page allows the provider to manage ownership information. Providers can add, edit, or end-date ownership information in the Re-verification application.

denter a marked field			
ndicates a required field			Legend
o you have one or more Shareholde	ers/Partners with 5% o	or more ownership? Yes	
SHAREHOLDER/PARTNER INFORMATION			
- INDIVIDUAL			
Last Name :		First Name :	
Middle Name :		Suffix :	
Date of Birth:		SSN :	
Gender :			
Email :		Phone Number :	
I attest that I have entered th	e full legal name of th	e individual, and the individual does not have a middle name.	
Address Line 1 :			
Address Line 2 :			
City :			
State :			
ZIP Code :			
Relationship to Another Disclosing	None	Percent of Ownership/Control	
Benin Date :		End Date :	
Degiti Date .		Lind Date .	
			Ed
+ Business			
+ Business			
+ BUSINESS ·			
+ BUSTNESS -			
+ BUSINESS			
Add Shareholder/Partner			
Please complete the required info	rmation for each share	sholder/partner with 5% or more ownership.	
This shareholder/partner is:			
⊖ an individual ⊖ a business			

Exhibit 51. Ownership Information Page

Step	Action
1	Select the plus (+) sign next to the individual or business that needs to be reviewed or edited. The section will expand.





Ownership Information				
* indicates a required field				Legend 🔻
De very have one or more Charabeld.	/Dt	¥		
Do you have one or more sharehous	ars/Partners with 5% or more ownership:	Tes		
SHAREHOLDER/PARTNER INFORMATION	I			f
- INDIVIDUAL -	(AUTHORIZEDINDIVIDUAL)			
Last Name :	1888.00	First Name :	100.00	
Middle Name :		Suffix :		
SSN :	100000000000000000000000000000000000000			
Gender :	18.000.000			
Email :	1011010-001-002-01042-01042	Phone Number :	111111111111	
☑ I attest that I have entered t	the full legal name of the individual, and t	he individual does not have a mido	lle name.	
Address Line 1 :	(0.0) 0.000.000			
Address Line 2 :				
City :	100.0.0.0.000			
State :				
ZIP Code :	10.000011100101			
Relationship to Another Disclosing Person :	None	Percent of Ownership/Control Interest :	100 %	
Begin Date :	1117011000	End Date :		1
				Edit
Add Shareholder/Partner				
Please complete the required info	rmation for each shareholder/partner with	5% or more ownership.		
* This shareholder/partner is:				
O an individual O a busines	5			
	-			
				*
« Previous			Please be sure to con required fields with valid	content. Next))

Exhibit 52. Ownership Information Page: Edit Ownership Information

Step	Action
1	Select Edit to update owner information or end date if the individual or business is no longer
	an owner of the organization.

6.3 AGENTS AND MANAGING EMPLOYEES PAGE

The **Agents and Managing Employees** page allows the provider to manage relationships. Providers can add, edit, or end-date managing relationships in the Re-verification application.

Note: An MCR is not required if the record has missing or invalid managing employee information.





indicates a required field					Legend	
RELATIONSHIP DISCLOSURE						
As required by 42 CFR 1002.3, pro- Funds Transfer (EFT) authorized inc	viders must disclose ti lividual.	he following for each	Individual officer, managing emplo	oyee, director, board memb	er, and Electronic	
Failure to provide the required infor	mation may result in	a denial for participa	ition.			
Does the applicant have any agent(s) and/or managing e	mployee(s)? Yes				
Managing Relationships						
Please add all managing relationsh	ilps below.					
+ MANAGING RELATIONSHIP -		(MANAGING COP	ітаст)			
+ MANAGING RELATIONSHIP -	(Au	THORIZED INDIVID	DUAL MANAGING CONTACT)			
Add Relationship	Telde and allele dates we	d hollow				
Please complete all the required i	leids and trick the Ad	a button.	the Electr Manual			
Middle Name:			Suffix:	Select One 🗸		
	(Enter your full mid	dle name)		Delet one		
* Date of Birth:	mm/dd/yyyy	23	* SSN:			
* Email:			* Phone Number:	(000) 000-0000		
* Business Relationship:	Select One V		Relationship to Another Disclosing Person:	Select One 👻		
$\hfill\square$ I attest that I have entered th	e full legal name of th	e individual, and the	individual does not have a middle	name.		
* Address Line 1:						
Address Line 2:						
* City:						
* State:		~				
* ZIP Code:	0000-0000				2	
					Add C	lear
					Latensi (er	
Previous					N	ext

Exhibit 53. Agents and Managing Employees Page

Step	Action
1	Expand the section that needs to be updated.
2	Select Edit.





distant a calculated Field	and the second		C
orates a required risid			Legend
RELATIONSHIP DISCLOSURE			
As required by 42 CFR 1002.3, pro Funds Transfer (EFT) authorized in	viders must disclose the following for ea dividual.	ch individual officer, managing employee, director, l	board member, and Electronic
Failure to provide the required info	rmation may result in a denial for partic	pation.	
Does the applicant have any agent(s) and/or managing employee(s)? Yes		
Managing Relationships			
Please add all managing relationsh	tips below.		
- MANAGING RELATIONSHIP	(AUTHORIZED INDIVIDUA	L MANAGING CONTACT)	
Last Name :		First Name :	
Middle Name :		Suffix 1	
SSN :	***.**.		
3 Email :		Phone Number :	
Business Relationship :	Managing Employee		
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 :			
Begin Date:	12/15/2015	End Date:	(
			1 million

Exhibit 54. Agents and Managing Employees Page: Add/Update Information

Step	Action
3	Add or update required information.
4	Select Save.





6.4 RE-VERIFICATION APPLICATION – ACCREDITATION PAGE

The **Accreditation** page allows the user to view or add accreditation. The **Accreditation Type** for required accreditations may be populated as read only. If the **Accreditation Type** has not been populated, the user can select the **Accreditation Type** from the drop-down list and enter the remaining required fields.

Note: The Accreditation page only displays for Individual Providers.




Re-Verification Application - Accreditation A A Help ates a requ Legend 7 ACCREDITATIONS Add Accreditation Select an accreditation type from the drop down list and provide the accreditation number Accreditation Type: -- Select One --Accreditation #: Effective Dete: mm/dd/yyyy -05 Expiration Date: imm/dd/ywww 100 Add Clear CERTIFICATIONS . CERTIFICATION - CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) * CERTIFICATION - DRUG ENFORCEMENT AGENCY (DEA) uld Certificatio 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 Certification Type: - Select One --Certifying Entity: -- Select One --State: NORTH CAROLIF + Certification #: Effective Date: mm/dil/yyyy 32 Expiration Date: mm/dd/yyyy III Add Clear LICENSES Taxonomy 207Q00000X - Family Medicine requires the following License Type: · DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO) OR MD FACULTY LIMITED BY STATE MEDICAL BOARD LICENSE - DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO) OR MD FACULTY LIMITED By STATE MEDICAL BOARD Licensie Agency: STATE MEDICAL BOARD License Type: DOCTOR OF MEDICINE (MD) OR DOCTOR OF OSTEOPATHIC MEDICINE (DO) OR MD FACULTY LIMITED State: NORTH CAROLINA License #: Effective Date: 07/19/1997 Expiration Date: 06/30/2022 Edit. Add License Select a license type from the drop down list and provide the license number. License Agency: -- Select One ---License Type: - Select One --State: NORTH CAROLD ~ License #: Effective Date: mm/dd/vyvy Expiration Date: mm//dd/yyyyy 125 105 Add Clear II Previous Next in

Exhibit 55. Re-Verification Application – Accreditation Page

Step	Action
1	Review, edit, and/or enter your board certifications information such as:
	Drug Enforcement Agency (DEA).

Save Drafs Delete Draft





Step	Action
	Certification Type
	Certifying Entity
	State – Select the state in which you are certified from the drop-down menu.
	Certification #
	Effective Date
	Expiration Date
2	Select Add.
3	Select Next.

6.5 PROVIDER SUPPLEMENTAL INFORMATION PAGE

The Provider Supplemental Information Page allows the user to enter work history, education, and current malpractice information.

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

idicates a required field					Legend
VORK HISTORY					
Enter your work history as a health more than six months, please uplo	n professional for the	e past 5 years. Work h larifying the gap upon	nistory prior to 5 years ago is not ne application submission.	eded. If there is a gap in	your employment of
Add Work History					
* Company Name:			* Job Title:		
* Start Date:	mm/dd/yyyy		* End Date:	mm/dd/yyyy	
					Add
					ſ
DUCATION					
Enter your highest level of education	on completed.				
Add Education History					
* School Name:			* Degree:		
* Start Date:	mm/dd/yyyy		* Graduate Date:	mm/dd/yyyy	
					Add
CURRENT MALPRACTICE INSURANCE COV	ERAGE				
Medical providers should carry pro your profession, including allegatio you at any time after you have see	fessional liability cov ns of malpractice. L en a patient.	verage, often called m iability insurance offer	alpractice insurance. This insurance rs essential financial protection beca	covers your exposure to l use a malpractice suit car	iability arising from be brought against
Enter your current malpractice insu a copy of the federal tortletter or a	urance coverage. Up In attestation from t	oon submission of the he practitioner of fede	application, upload a copy of the ins ral tort coverage.	surance face sheet from th	e malpractice carrier or
Do you have malpractice insuran Yes No	ce or are you covere	ed under a federal tort	?		

Exhibit 56. Re-Verification Application – Provider Supplemental Information Page





Step	Action
1	 In the Work History section of the Provider Supplemental Information page, enter your work history as a health professional: Company Name – Employer name Job Title – Position/job title Start Date – Start date of the job title at this company End Date – End date of the job. If you still hold this job title at this company, enter 12/31/9999. If there is a gap in the Individual provider's work history of 6 months or more, the provider is required to upload written documentation explaining any gaps that occurred in the past 5 years.
2	 In the Education section, enter your Education information: School Name – School or institution name Degree – Highest degree Start Date – Date started at the school or institution Graduation Date – Date graduated from the school with this degree
3	 In the Current Malpractice Insurance Coverage section, enter/select the following: Do you have malpractice insurance or are you covered under a federal tort? – Select Yes if you have malpractice insurance or are covered under a federal tort Malpractice Type – Select the type of malpractice coverage Insurance Agency Name – Enter the name of the malpractice insurance agency Amount – Enter the amount of malpractice coverage Effective Date – Effective date of the coverage Expiration Date – Expiration date of the coverage
4	Select Next.





6.6 FEDERAL REQUIREMENTS PAGE

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

If the provider has not met these requirements, the **Federal Requirements** page will populate in the Re-verification application.

			Legend
FEDERAL SITE VISIT			
Pared upon the health plane and	tavanamu cadae i	you have applied your application requires you to complete a Faderal Cit	a Visit before your application
will be approved.	a taxonomy codes	you have appred, your application requires you to complete a rederal Sit	e visit before your application
If you completed a Federal Site proof, select NO.	Visit with another s	state Medicaid program, you must be able to provide proof of completion	. If you are unable to provide
* Have you completed the Federal	site visit for this site	e within the past 12 months to another state or Medicare?	
	OTHER STATE	×	
* Other State:	-	☑ 2	
FEDERAL FEE			
Section 6401(a) of the ACA requ application requires you to pay t	ires the State Med he Federal Fee. other state Medica	ficaid Agency to impose the fee. Based upon the health plans and taxono aid program, you must be able to provide proof of payment. If you are ur	my codes you have applied, your
If you paid the Federal Fee to an			
If you paid the Federal Fee to an Have you paid the Federal Fee for	or this site within the	past 12 months to another state or Medicare?	
If you paid the Federal Fee to an # Have you paid the Federal Fee fo	or this site within the OTHER STATE	p paot 12 months to another state or Medicare?	
If you paid the Federal Fee to an # Have you paid the Federal Fee fo # Other State:	or this site within the	p paot 12 months to another state or Medicare?	
If you paid the Federal Fee to an # Have you paid the Federal Fee fo # Other State:	or this site within the	popol 12 months to another state or Medicare?	5
If you paid the Federal Fee to an # Have you paid the Federal Fee fo # Other State: Previous	or this site within the	p paat 12 months to another state or Medicare?	ase he sure to complete all Next. I

Exhibit 57. Federal Requirements Page

Step	Action
1	 Federal Site Visit: Have you completed the Federal site visit for this site to NC Medicaid, another state or Medicare? Select NO if you have not completed a Federal site visit for this location with either another state or Medicare. Select MEDICARE if completed with Medicare. Select OTHER STATE if completed for another state Medicaid program. Note: If you select NO, Public Consulting Group (PCG) will contact you after the application has been submitted to set up the site visit. If you select MEDICARE, CSRA will confirm the site visit completion with Medicare. If you select OTHER STATE, you are required to upload proof of completion as part of the application submission.
2	Other State: If applicable, select the state.
3	 Federal Fee: Have you paid the Federal Fee for this site to NC Medicaid, another state or Medicare? Select NO if you have not paid a Federal Fee for this location with either another state or Medicare. Select MEDICARE if paid to Medicare. Select OTHER STATE if completed for another state Medicaid program. Note: If you select NO, upon submission of this application, you will be directed to PayPoint to pay the fee.





Step	Action
	If you select MEDICARE, CSRA will confirm the payment was made with Medicare.
	 If you select OTHER STATE, you are required to upload proof of payment as part of the application submission. If OTHER STATE is selected, the provider is required to upload proof of payment as part of the application submission.
4	Other State: If applicable, select the state.
5	Select Next to continue.





6.7 EXCLUSION SANCTION INFORMATION PAGE

		-
	WARNINGH FAILURE TO DISCLOSE WILL RESULT IN AN APPLICATION DENIAL AND CAUSE ALL NON-DMH HEALTH PLANS TERMINATE, RE-ENROLLMENT WILL BE REQUIRED.	5 1
Denusion	SANCTION INFORMATION	
The que 1002.3	stions below must be answered for the enrolling provider, its owners, and agents? in accordance with 42 CFR 455.100; 101; 104; 106 and 42 C	**
• "An gen bos • All /	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 em eral managers, husiness managers, office managers, administrators; Electronic Funds Transfer (EFT) authorized individuals, individual officers, ind members, etc. applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.	di
clearly in	question answered yes, you must submit a complete copy of the applicated criminal complaint, consent there, documentation, and/or that dis idicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.	ps
 A. Hat felony, or Yes 	s the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled no contest entered into a pre-trial agreement for a lelony? No	D
Please	add up to 5 Infraction/Conviction Dates.	
- Inr	RACTION/CONVICTION DATES	
	Infraction/Conviction Date	
d 01/0	Idd/yyyy II	
Sectores.		
	• No • No • The scaling transmiss appropriate memory or assort much been dealed confirment have exceeded and did to be to be scale with the scale of the scal	
C. Ha from Med or profest private he suspende health int O Yes	In the set of the s	will bu ter re
C. Ha from Med or profess private he suspende health im O Yes D. Ho corporatio affisiated O Yes	The applicant, managing employees, owners, or agent sever been derived enrollment, been suspended, excluded, terminated, or involuntarily is face, Medicaid, or any other government or private health care or health insurance grogram in any state; or been employed by a corporation, a signal 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 grogram in any state; or been employed by a corporation, a signal association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health care or health insurance grogram in any state; or ever been directly or indirectly affiliated with a provider or supplier that h, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health care or health care or program in any state; Is the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or ever been directly or indirectly afficiant is any state; or ever been directly or indirectly afficiant in any state; or ever been directly or indirectly afficiant or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state; or ever been directly or indirectly afficiant or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state;	wit but the second seco
 C. Ha from Med or profess private his suspende health Int O Yes D. Ha corporatiliattilated Yes E. Has or Progra Yes 	 the applicant, managing employees, owners, or agent sever been derived enrollment, been suspended, excluded, terminated, or involuntarily of kare, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a corporation, a sional 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 been employed by a corporation, a sional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other govern private health care or bealth care or bealth care or private health care or bealth care or bealth care or bealth care and the private health care or private health care or bealth care or private health care o	with but has not we dire
C. Ha from Med or profes private h suspende health im O Yes * D. Ha corporation O Yes * E. Has or Progra O Yes * F. Doe affiliated O Yes	The applicant, managing employees, owners, or agent sever been derived enrollment, been suspended, excluded, terminated, or involuntarily of taxes, Medicaid, or any other government or private health care or health insurance grogram in any state; or been employed by a corporation, a signal 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 grogram in any state; or been employed by a corporation, a signal association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health insurance grogram in any state; or ever been directly or indirectly affiliated with a provider or supplier that h, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health care or program in any state; or ever been directly or indirectly affiliated with a provider or supplier that ever had suspended payments from Medicare or Medicaid in any state; or ever been directly or individual association that ever had suspended payments from Medicare or Medicaid in any state; or ever been directly or individual provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state? No Is the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Feder m, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full? No Is the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid; or ever been directly or in with a provider or supplier that has uncollected debt owed to Medicare. Medicaid, or CHIP?	without the second seco
C. Ha from Med or profes private his suspende Nealth ins Ves D. Ho Corporatilisated Ves E. Has or Program Ves E. Has or Program Ves E. Has or Program Ves E. Has C. Ho S. C. Ha adhliated Ves C. Ha adhliated Ves C. Ha S. C. Ha adhliated Ores C. Ha S. C. Ha S. C. Ha S. C. Ha S. C. Ha S. C. Ha S. C. Ha Subuse of O. Yes C. Ha Subuse of O. Yes S. C. Ha Subuse of C. Ha S	 The applicant, managing employees, owners, or agent sever been derived enrollment, been suspended, excluded, terminated, or involuntarily of taxe, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a corporation, a signal association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or bealth insurance program in any state; or ever been directly or indirectly affiliated with a provider or supplier that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or bealth care or bealth care program in any state; No s the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or ever been directly or indirectly are state; or ever been directly or indirectly in any state; No s the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Feder m, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full? No is the applicant, managing employees, owners, or agents owner money to Medicare or Medicaid that has not been paid; or ever been directly or in with a provider or supplier that has uncollected debt owed to Medicare, Medicaid, or chip? No is the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or ever been directly or in with a provider or supplier that has uncollected debt owed to Medicare. Medicaid, or cHIP? No is the applicant, managing employees, owners, or agents owner money to Medicare or Medicaid that has not been paid; or ever been directly or in with a provider or supplier that has uncollected debt owed to Med	with but has a set of the set of
C. Ha from Med or profes private h suspende health in O Yes D. Ho corporation of Yes E. Has or Progra O Yes E. E. Doe adfiliated O Yes C. Ha S. B. Ho Yes C. Ha S. B. Ha or Progra O Yes C. Ha S. B. Ha O Yes C. Ha S. B. S.	 The applicant, managing employees, owners, or agent sever been derived 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, a signal 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 over been directly or indirectly affiliated with a provider or supplier that h d, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health insurance program in any state; or ever been directly or indirectly affiliated with a provider or supplier that h, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health insurance program is any state; or ever been directly or indirectly affiliated with a provider or supplier that ever had suspended payments from Medicare or Medicaid in any state; or ever been directly or individu and provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state; No No No s the applicant, managing employees, owners, or agents ever had civil inonetary penalties levied by Medicare, Medicaid, or other State or Feder m, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full? No s the applicant, managing employees, owners, or agents ever been convicted under federal or state lew of a criminal offense related to the negl a patient in connection with the delivery of any health care go	will but the set of th
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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.
	For each question answered Yes , the provider 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.
	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.

6.8 REVIEW APPLICATION PAGE

Selecting the **Review Application** button displays a window that allows the ES user to open a PDF file of the application. The ES user can print and review the application for accuracy before submitting.

k indicates a required field	Legend 🔻
ELECTRONIC SIGNATURE - EMAIL CONFIRMATION	
 Please confirm that the email address below is correct. If you dont already have one, an Electronic Signatu upon submitting the next page. You will need access to this email address to retrieve/reset your PIN and c If the email below is incorrect, you may now navigate back to the <u>Basic Information page</u> to update it. (Rei <u>Information page</u> to store your change.) 	re PIN will be sent to this address omplete this Online Application. nember to click Next on the <u>Basic</u>
Contact Email:	
REVIEW APPLICATION To review your application in Adobe PDF format, click ' Review Application ' below. If you have successfully con your provider enrollment application and are satisfied the information is complete and accurate, you may procee Electronic Application page by clicking ' Next '.	npleted all required information for ad to the Attachments/Submit
	2 Review Application 🔎
ASSIGN APPLICATION TO OFFICE ADMINISTRATOR When you have deemed the application complete and ready for the Office Administrator (OA) to review and sub Assign Application to OA button.	2 Review Application \searrow
Assign APPLICATION TO OFFICE ADMINISTRATOR When you have deemed the application complete and ready for the Office Administrator (OA) to review and sut Assign Application to OA button.	2 Review Application mit the application, select the 3 Assign Application to 0A
ASSIGN APPLICATION TO OFFICE ADMINISTRATOR When you have deemed the application complete and ready for the Office Administrator (OA) to review and sul Assign Application to OA button.	2 Review Application mit the application, select the 3 Assign Application to 0A Hease be sure to complete 4 Next »

Exhibit 59. Review Application Page





Step	Action
1	Confirm the Contact Email listed is correct; if not, use the provided hyperlink to access the Basic Information page to update it.
2	Select Review Application to review the information entered for accuracy.
3	Select Assign Application to OA to assign the application to the OA for review and submission, where applicable. Note : An e-mail will be sent to the OA notifying them that the application is ready to be signed and submitted.
4	Select Next to continue.

Note: When the ES user selects the **Assign Application to OA** button, they will be redirected to the **Status and Management** page.

The **Assign Application to Office Administrator** section displays only when the logged-in user is the ES user.





7.0 Maintain Eligibility Application

A provider with no claim activity in the last 12 months will be notified that they must complete a Maintain Eligibility application in NCTracks. The provider must attest electronically to remain active or the system will terminate all health plans (except Division of Mental Health [DMH]).



Exhibit 60. Provider Portal Home Page

Step	Action
1	From the Provider Portal Home page, select Status and Management.

The **Status and Management** page displays. To begin a Maintain Eligibility application, scroll down to the **Maintain Eligibility** section.

The following provider accounts associated with your NCID require a Maintain Eligibility Application to be completed by the due date indicated. Please select								
the record	I with which you would like	to proceed, then click 'Submit'.						
RECOR	D RESULTS							
	NUDY / Altornian LTD	Nama	DRA Name	ZIP Code	Due Date			
Select	NP1/Atypical ID	Harrie	Don name		Due Duce			

Exhibit 61. Status and Management Page: Maintain Eligibility Section

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





The pages look exactly like the Re-verification application pages except that the **Exclusion Sanction Information** page will not display. See the exhibits in <u>Section 6.0</u>.

Once the Maintain Eligibility application is submitted, the provider record will be updated to indicate that the provider wishes to remain active. **Note**: The submitted Maintain Eligibility application will appear on the **Status and Management** page in the **Submitted Applications** section with a status of "Approved".





Addendum A. Help System

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

- Navigational breadcrumbs
- System-Level Help Indicated by the "NCTracks Help" link on each 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

Navigational Breadcrumb



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

System-Level Help



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

Screen-Level Help



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





Form Legend

Legend 🔨 🔻
📰 Calendar 🛛 😡
Add New Entry
📝 Editing Entry
🥜 Pending Update
Pending Deletion
+ Expand Section
 Collapse Section
A Row Error
🖉 File Attached
🔽 Audit
* Required Field

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

Data / Section Group Help

PATIENT INFORMATION ************************************	or	* SSN: * Date of Birth: mm/dd/yyyy	
Date of Service * From: mm/dd/yyyy		* To: mm/dd/yyyy	Verify Clear
			+

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

Tooltip Help

Vorify Dationt				
Identifies the Account based on the User ID used to log into the system				
Account Information: NCMMIS	5			

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