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CSRA
a General Dynamics Information
Technology, Inc. company



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

September 25, 2024

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. |

Provider Portal Login

Important Announcement

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

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

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

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

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

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

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

If you encounter issues during login or authentication, please contact the Department of Information Technology (DIT) helpdesk at **919-754-6000** or **800-722-3946**.

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

The **NCTracks Web Portal** contains information that is private and confidential.

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

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

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

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

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

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

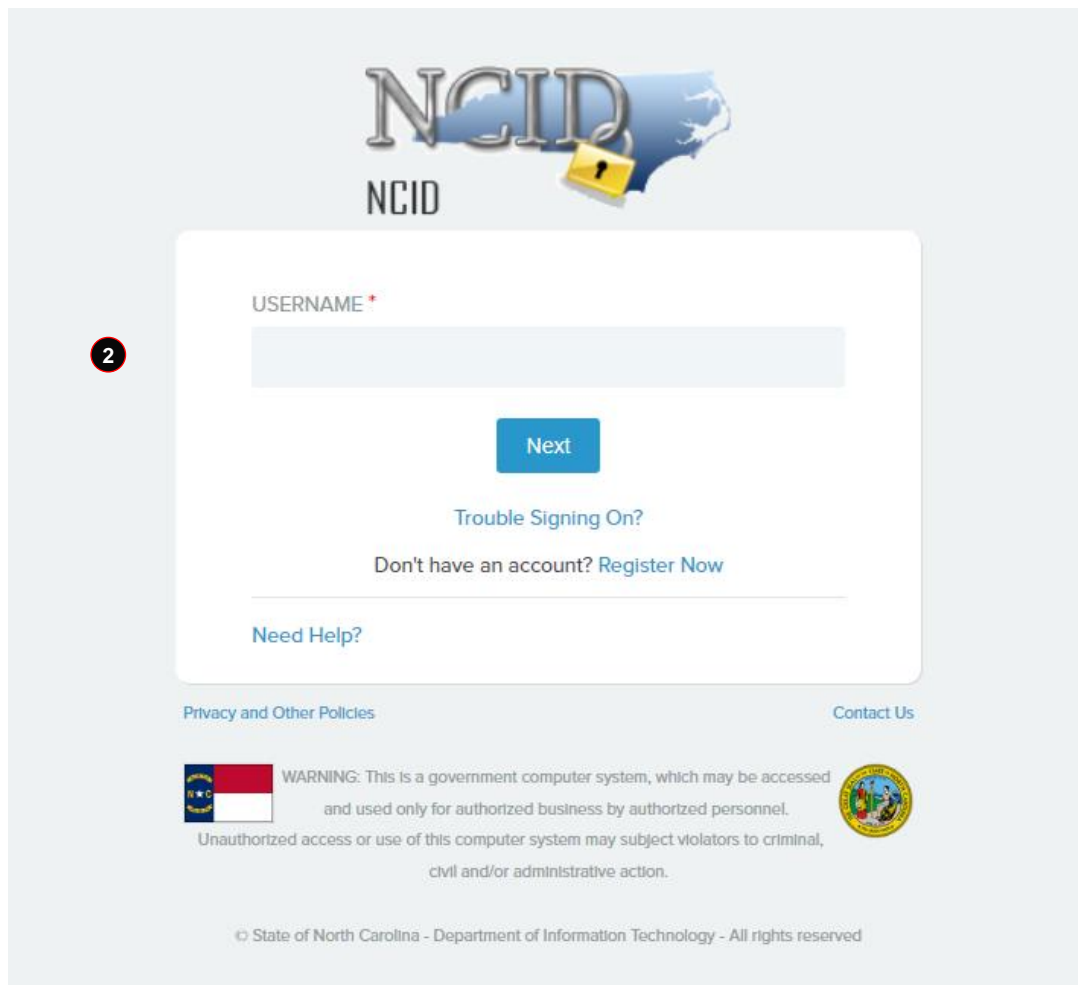
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NC Department of Health and Human Services

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Exhibit 2. NCTracks Login Page

| Step | Action |
|------|--|
| 1 | Select the NCTracks Secure Portal button. |



The image shows the NCID (North Carolina Identification) login page. At the top, there is a logo with the text "NCID" and a map of North Carolina. Below the logo, there is a white box containing the login form. The form has a "USERNAME" label with a red asterisk, followed by a text input field. Below the input field is a blue "Next" button. Under the button are two links: "Trouble Signing On?" and "Don't have an account? Register Now". At the bottom of the white box is a link "Need Help?". Below the white box, there are two links: "Privacy and Other Policies" and "Contact Us". At the bottom of the page, there is a warning message: "WARNING: This is a government computer system, which may be accessed and used only for authorized business by authorized personnel. Unauthorized access or use of this computer system may subject violators to criminal, civil and/or administrative action." To the left of the warning is a small North Carolina flag, and to the right is a circular seal. At the very bottom, there is a copyright notice: "© State of North Carolina - Department of Information Technology - All rights reserved". A red circle with the number "2" is placed to the left of the username input field.

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. |

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

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

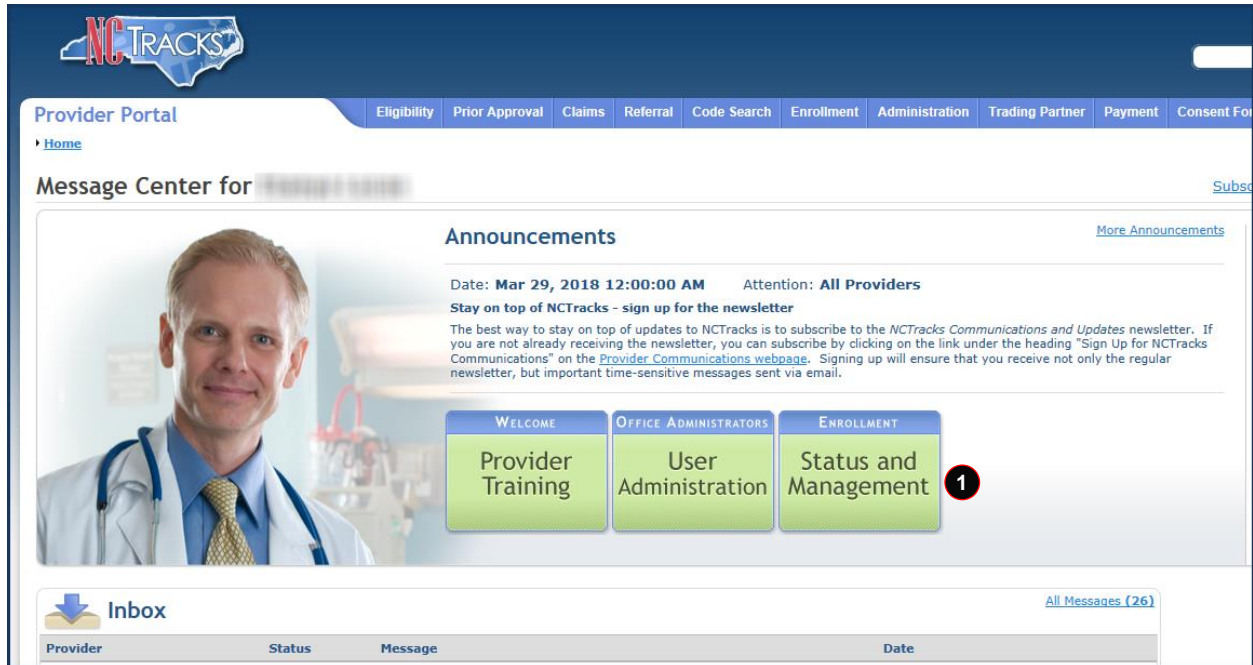


Exhibit 3. Provider Portal Home Page

| 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.

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**.

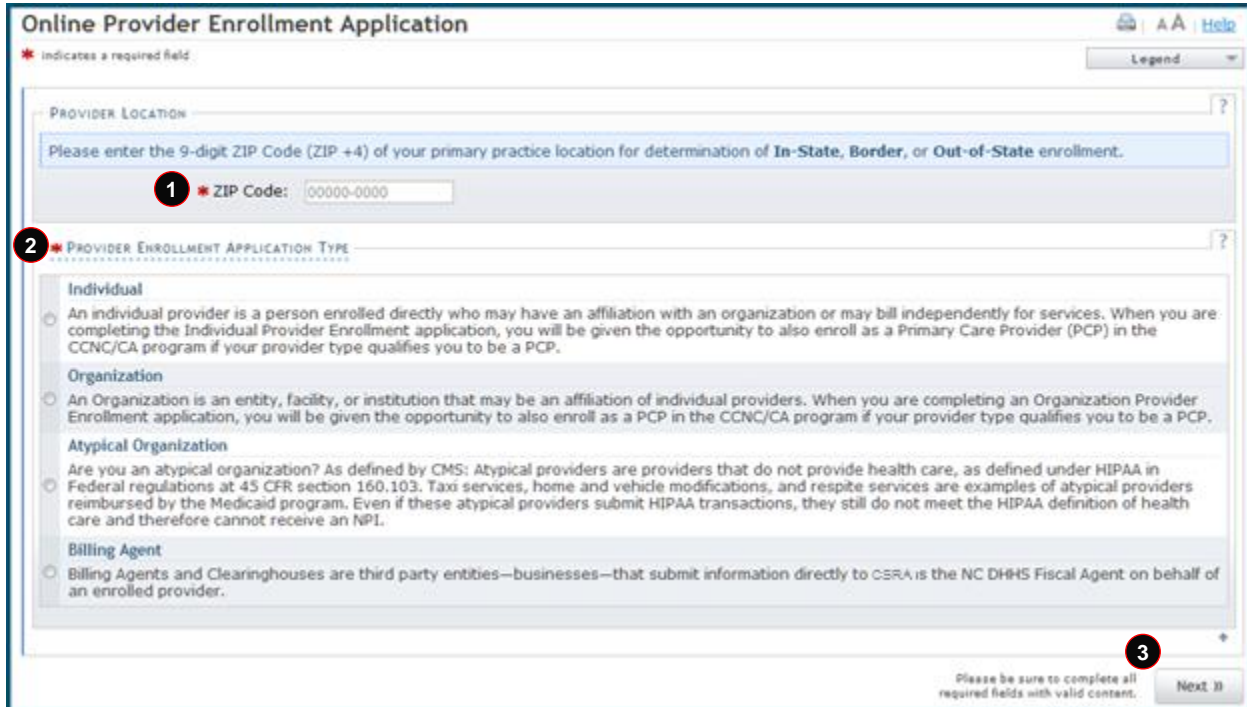


Exhibit 6. Online Provider Enrollment Application Page

| 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 [Section 3.5, Individual Basic Information Page](#).

Organization Basic Information

* indicates a required field

Legend

1 IDENTIFYING INFORMATION

* Organization Name:

* EIN: 00-0000000 * NPI: 0000000000

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

ZIP Code: 27707-0000

2 DOING BUSINESS AS (DBA)

* Do you operate under a trade or company name?

☐ Yes ☐ No

3 OWNERSHIP INFORMATION

* Business Type: -- Select One --

CITY/MUNICIPALITY
 CORPORATION
 FEDERAL
 INDIAN HEALTH SERVICES
 LIMITED LIABILITY CORPORATION (LLC)
 LOCAL GOVERNMENT AGENCY
 NON-PROFIT
 PARTNERSHIP
 STATE

OFFICE ADMINISTRATOR (A)

Individual authorized to role currently belongs to

* Last Name: 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: <ul style="list-style-type: none"> • 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 | Action |
|------|--|
| | <ul style="list-style-type: none"> • State: Select if the entity is owned by the state in which it operates. |

4 REGISTERING WITH NC SECRETARY OF STATE

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

☒ Yes ☐ No

* Secretary of State ID #:

5 OFFICE ADMINISTRATOR (AUTHORIZED INDIVIDUAL)

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

* 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

* User ID (NCID): -- Select One --

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

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

☐ Owner ☐ Managing Employee

EFFECTIVE DATE REQUESTED

The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment may not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received and may not precede, as applicable, the current date of your licensure or the current date of your letter of endorsement.

Note: CCNC/CA participation effective date may not be retroactively requested.

7 * Effective Date: 04/24/2015

Please be sure to complete required fields with valid content **8** Next >

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. |

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: <ul style="list-style-type: none"> • Alpha (A – Z) • Numeric (0 – 9) • Hyphen (-) • Ampersand (&) |
| 5 | Rendering/Attending Only Provider: Select Yes or No . |

OWNERSHIP INFORMATION

6 * Business Type: -- Select One --
 -- Select One --
 SELF (INDIVIDUAL FILING UNDER A SSN)
 SINGLE-OWNER LLC
 SOLE PROPRIETOR

7 OFFICE ADMINISTRATOR (AUTHORIZED INDIVIDUAL)

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

☐ Authorized Individual is the same as enrolling provider

* Last Name: * First Name: MICHELLE
 Middle Name: Suffix: -- Select One --
 (Enter your full middle name)

* Contact Email:

* Office Phone #: (919) 333-2222 ext. Office Fax #: (000) 000-0000

* User ID (NCID): uatdemoprovider

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

EFFECTIVE DATE REQUESTED

The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment may not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received and may not precede, as applicable, the current date of your licensure or the current date of your letter of endorsement.
 Note: CCNC/CA participation effective date may not be retroactively requested.

8 Effective Date: 03/18/2013

Please be sure to complete all required fields with valid content. 9 Next >>

Exhibit 10. Individual Basic Information Page #2

| Step | Action |
|------|---|
| 6 | <p>Ownership Information: Select the Business Type from the drop-down menu.</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Self – Select this type if you are an Individual filing under an SSN. Single-Owner LLC – Select this type (filing status) if you are an Individual who intends to operate as a sole proprietor and act as the sole owner and manager. Sole Proprietor – Select this type (filing status) if you are an Individual filing under an EIN. |
| 7 | <p>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).</p> |
| 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.

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.

Ownership Information

* indicates a required field

Legend

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

SHAREHOLDER/PARTNER INFORMATION

| + | INDIVIDUAL - | |
|---|--------------|-----------------|
| + | INDIVIDUAL - | |
| - | INDIVIDUAL - | --- NEWLY ADDED |

Last Name :

First Name :

Middle Name :

Suffix :

Date of Birth :

SSN : ***-**-

Gender :

Email :

Phone Number :

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

Address Line 1 :

Address Line 2 :

City :

State :

ZIP Code :

Relationship to Another Disclosing Person : **None**

Percent of Ownership/Control Interest : **5 %**

Begin Date : **09/16/2015**

End Date :

2

3 Add Shareholder/Partner

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

* This shareholder/partner is:

☐ an individual ☒ a business

Business Information

* Business Legal Name:

* EIN:

* Address Line 1:

Address Line 2:

* City:

* State:

* ZIP Code:

* Percent of Ownership/Control Interest: %

* Begin Date:

4

Previous Next

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

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 . <ul style="list-style-type: none"> 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.

The screenshot shows the 'Provider Portal' interface. On the left is a sidebar with navigation links: Home, Provider Enrollment, Online Provider Enrollment Ag..., Individual Basic Information, Home and Location, Choose Health Plan, Enrollment Plan Selection, Address, and Service Location. The 'Addresses' link is highlighted with a red circle and the number 1. The main content area is titled 'Addresses' and contains a section for 'Primary Physical Location'. This section includes fields for Office Phone #, Office Fax #, Address, Address Line 1, Address Line 2, City, ZIP Code, State (dropdown menu set to NORTH CAROLE), and County (dropdown menu set to Orange). There is also a 'Servicing Counties' section. A 'Verify Address' button is located at the bottom right of the address entry section.

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). |

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.

| | | | |
|--------------------------------------|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> NEW HANOVER | <input type="checkbox"/> NORTHAMPTON | <input type="checkbox"/> ONSLOW | <input type="checkbox"/> ORANGE |
| <input type="checkbox"/> PAMLICO | <input type="checkbox"/> PASQUOTANK | <input type="checkbox"/> PENDER | <input type="checkbox"/> PERQUIMANS |
| <input type="checkbox"/> PERSON | <input type="checkbox"/> PITT | <input type="checkbox"/> POLK | <input type="checkbox"/> RANDOLPH |
| <input type="checkbox"/> RICHMOND | <input type="checkbox"/> ROBESON | <input type="checkbox"/> ROCKINGHAM | <input type="checkbox"/> ROWAN |
| <input type="checkbox"/> RUTHERFORD | <input type="checkbox"/> SAMPSON | <input type="checkbox"/> SCOTLAND | <input type="checkbox"/> STANLY |
| <input type="checkbox"/> STOKES | <input type="checkbox"/> SURRY | <input type="checkbox"/> SWAIN | <input type="checkbox"/> TRANSYLVANIA |
| <input type="checkbox"/> TYRRELL | <input type="checkbox"/> UNION | <input type="checkbox"/> VANCE | <input checked="" type="checkbox"/> WAKE |
| <input type="checkbox"/> WARREN | <input type="checkbox"/> WASHINGTON | <input type="checkbox"/> WATAUGA | <input type="checkbox"/> WAYNE |
| <input type="checkbox"/> WILKES | <input type="checkbox"/> WILSON | <input type="checkbox"/> YADKIN | <input type="checkbox"/> YANCEY |

3

1099 REPORTING/PAY-TO ADDRESS

All provider records with the same Employee Identification Number (EIN) must have the same 1099 Reporting Address. You only need to submit one application per EIN. Upon application approval, all records with the same EIN will be updated with the new address.

* Do you have a separate Pay-To address?

☐ Yes ☐ No

4

CORRESPONDENCE ADDRESS

This is the address where all paper and accounting correspondence is to be mailed.

* Do you have a separate correspondence address?

☐ Yes ☐ No

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 . |

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.

Exhibit 16. Taxonomy Classification Page #1

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

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 . |

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.

The screenshot shows the 'Add Services and Endorsements' page. On the left is a sidebar with links like 'Organization Basic Information', 'Terms and Conditions', etc. The main area has a table titled 'SERVICE LOCATIONS' with columns 'Select', 'Location', and 'Form Status'. The 'Form Status' column shows 'Incomplete' for all rows. A red circle '1' is over the 'Select' column, and a red circle '2' is over the 'Edit Location' button at the bottom right.

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. |

The screenshot shows the 'TAXONOMY CLASSIFICATION - 251800000X - CASE MANAGEMENT' section. It includes a 'Service Type' section with a question 'Do you wish to add CAP/DA services OR CAP/C services?'. Below are two tables: 'CAP/DA SERVICES' and 'CAP/C SERVICES'. The 'CAP/DA SERVICES' table has a 'Select' column with 'Case Management' checked. The 'CAP/C SERVICES' table has a 'Select' column with 'Vehicle Modification', 'Case Management', 'Care Giver Training', and 'Community Transition Funding' checked. A red circle '3' is over the 'Service Type' section, '4' is over the 'CAP/DA services' checkbox, '5' is over the 'CAP/DA SERVICES' table, '6' is over the 'Save Location' button, and '7' is over the 'Next' button.

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.

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 . |

Accreditation:

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

Please provide certification, license, accreditation, and endorsement information that qualifies you to render services.

ACCREDITATIONS

If one or more accreditations is required for your taxonomy, enter the accreditations required fields and click the Add button.

Taxonomy **261QB0400X - Birthing** requires the following Accreditation Type:

- Commission for Accreditation of Free-standing Birthing Centers

ACCREDITATION - COMMISSION FOR ACCREDITATION OF FREE-STANDING BIRTHING CENTERS

Accreditation Type: Commission for Accreditation of Free-standing Birthing Centers

* Accreditation #:

* Effective Date:

Expiration Date:

Copy this accreditation to all service locations: ☐

4

CERTIFICATIONS

If one or more certifications is required for your taxonomy, enter the certifications required fields and click the Add button.

Taxonomy **261QF0050X - Family Planning, Non-Surgical** requires the following Certification Type:

- Planned Parenthood Agency By Planned Parenthood Federation of America

CERTIFICATION - PLANNED PARENTHOOD AGENCY BY PLANNED PARENTHOOD FEDERATION OF AMERICA

Certification Type: Planned Parenthood Agency

Certifying Entity: Planned Parenthood Federation of America

* State:

* Certification #:

* Effective Date:

Expiration Date:

Copy this certification to all service locations: ☐

6

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 . |

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 after-hours 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).

Agents and Managing Employees

* Indicates a required field

Legend

RELATIONSHIP DISCLOSURE

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, managing employee, director, board member, and Electronic Funds Transfer (EFT) authorized individual.
Failure to provide the required information may result in a denial for participation.

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

Managing Relationships

Please add all managing relationships below.

MANAGING RELATIONSHIP (AUTHORIZED INDIVIDUAL MANAGING CONTACT) --- NEWLY ADDED

Last Name :

First Name :

Middle Name :

Suffix :

Date of Birth :

SSN : ***-**-

Email :

Phone Number :

Business Relationship : **Agent**

☒ 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 : **NORTH CAROLINA**

ZIP Code :

2 Edit

Add Relationship

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

* Last Name:

* First Name:

Middle Name:

Suffix: -- Select One --

(Enter your full middle name)

* Date of Birth: mm/dd/yyyy

* SSN:

* Email:

* Phone Number: (000) 000-0000

* Business Relationship: -- Select One --

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

* Address Line 1:

Address Line 2:

* City:

* State: --

* ZIP Code: 00000-0000

Verify Address

Add Clear

3

4

« Previous

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

Next »

Save Draft Delete Draft

Exhibit 24. Agents and Managing Employees Page

PUG_PRV562

FINAL
PUG_PRV562 Enroll Specialist_V3.7

Page 29 of 78

| 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.

The screenshot shows the 'Hospital Admitting' page. At the top, there's a title bar with 'Hospital Admitting', a printer icon, a zoom icon, and a 'Help' link. Below the title bar, a legend indicates that an asterisk (*) denotes a required field. The main form area is titled '* HOSPITAL ADMITTING PRIVILEGES'. It contains a question: 'Does the enrolling provider have hospital admitting privileges?' with radio buttons for 'Yes' and 'No'. Below this is a section for 'Hospitals' with a sub-header 'Add County Hospitals'. A blue instruction box states: 'Choose a county and select the hospital(s) with which clinician or practice has admitting privileges. Once selections are made, you must click 'Add' button to store your entry. You may then repeat this process to select hospitals in other counties'. Below the instruction box, there's a dropdown for '* County:' with 'DURHAM' selected. Underneath is a section for '* Hospital(s):' with two columns: 'Available Options' and 'Selected Options'. The 'Available Options' column lists 'SELECT SPECIALTY HOSPITAL DURH', 'DUKE UNIVERSITY HOSPITAL', and 'DURHAM REGIONAL HOSPITAL'. The 'Selected Options' column shows 'NORTH CAROLINA SPECIALTY HOSPI'. Between the columns are buttons: 'Add >', 'Add All >', '< Remove', and '< Remove All'. At the bottom right of the 'Selected Options' column is an 'Add' button. At the very bottom of the page are 'Previous' and 'Next' navigation buttons, along with a note: 'Please be sure to complete all required fields with valid content.'

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.

The screenshot shows the 'Affiliated Provider Information' page. It includes a legend, a section for 'AFFILIATED PROVIDER INFORMATION' with a 'Do you wish to link or affiliate with another enrolled provider?' question (callout 1), and a section for 'AFFILIATED PROVIDERS'. The 'AFFILIATED PROVIDERS' section has a 'Add Affiliated Provider' button, a text input for 'Enter organization's NPI and click 'Lookup NPI'', and a 'Lookup NPI' button (callout 2). Below this are fields for 'Organization Name' and 'Enrollment Effective Date'. A section for 'Please select locations of affiliated provider.' includes a table with columns 'Location' and 'Do you wish to participate in CCNC/CA under this group?'. The table has one row with a checkbox (callout 3), a location name, and 'N/A' (callout 4). An 'Add' button is at the end of the table (callout 5). At the bottom, there are 'Previous' and 'Next' buttons, and a note 'Please be sure to complete required fields with valid contents.' (callout 6).

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

* indicates a required field

AA Help

Legend

1

WORK HISTORY

Enter your work history as a health professional for the past 5 years. Work history prior to 5 years ago is not needed. If there is a gap in your employment of more than six months, please upload documentation clarifying the gap upon application submission.

Add Work History

* Company Name:

* Job Title:

* Start Date:

mm/dd/yyyy

* End Date:

mm/dd/yyyy

Add

2

EDUCATION

Enter your highest level of education completed.

Add Education History

* School Name:

* Degree:

* Start Date:

mm/dd/yyyy

* Graduate Date:

mm/dd/yyyy

Add

3

CURRENT MALPRACTICE INSURANCE COVERAGE

Medical providers should carry professional liability coverage, often called malpractice insurance. This insurance covers your exposure to liability arising from your profession, including allegations of malpractice. Liability insurance offers essential financial protection because a malpractice suit can be brought against you at any time after you have seen a patient.

Enter your current malpractice insurance coverage. Upon submission of the application, upload a copy of the insurance face sheet from the malpractice carrier or a copy of the federal tortletter or an attestation from the practitioner of federal tort coverage.

* Do you have malpractice insurance or are you covered under a federal tort?

☐ Yes
☐ No

Previous

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

Next

Add Malpractice

* Malpractice type:

-- Select One --

* Effective Date:

mm/dd/yyyy

* Expiration Date:

mm/dd/yyyy

Add

Exhibit 27. Provider Supplemental Information Page

| Step | Action |
|------|--|
| 1 | <p>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.</p> <p>If there is a gap in the Individual provider's work history of 6 months or more, the provider is required to upload written documentation explaining any gaps that occurred in the past 5 years.</p> <ul style="list-style-type: none"> Company Name: Employer name Job Title: Position/job title Start Date: Start date of the job title at this company End Date: End date of the job. If you still hold this job title at this company, enter 12/31/9999. <p>Note: When entering work history, if the enrolling provider is currently a resident or intern, he/she should enter the details of that residency/internship such as:</p> <ul style="list-style-type: none"> Company Name: Healthcare Facility XYZ Job Title: Resident Start Date: Date residency/internship began End Date: 12/31/9999 if still a resident/intern |

| Step | Action |
|------|--|
| 2 | Education: Enter your Education information. <ul style="list-style-type: none">• School Name: School or institution name• Degree: Highest degree• Start Date: Date started at the school or institution• Graduation Date: Date graduated from the school with this degree |
| 3 | Current Malpractice Insurance Coverage: <ul style="list-style-type: none">• Do you have malpractice insurance or are you covered under a federal tort?: Select Yes if you have malpractice insurance or are covered under a federal tort.• Malpractice Type: Select the type of malpractice coverage• Amount: Enter the amount of malpractice coverage• Effective Date: Effective date of the coverage• Expiration Date: Expiration date of the coverage |

3.29 EXCLUSION SANCTION INFORMATION PAGE

Exclusion Sanction Information

* Indicates a required field

  [Help](#)

Legend

EXCLUSION SANCTION INFORMATION

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

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

For each question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.

* A. Has the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony, or entered into a pre-trial agreement for a felony?

☒ Yes ☐ No

Please add up to 5 Infraction/Conviction Dates.

INFRACTION/CONVICTION DATES

Infraction/Conviction Date

09/01/1999

mm/dd/yyyy

2 Add Clear

* B. Has the applicant, managing employees, owners, or agents ever had disciplinary action taken against any business or professional license held in this or any other state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?

☐ Yes ☒ No

* C. Has the applicant, managing employees, owners, or agent sever been denied enrollment, been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health care or health insurance program in any state; or ever been directly or indirectly affiliated with a provider or supplier that has been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health care or health insurance program in any state?

☐ Yes ☒ No

* D. Has the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state; or ever been directly or indirectly affiliated with a provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state?

☐ Yes ☒ No

* E. Has the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal Agency or Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?

☐ Yes ☒ No

* F. Does the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid; or ever been directly or indirectly affiliated with a provider or supplier that has uncollected debt owed to Medicare, Medicaid, or CHIP?

☐ Yes ☒ No

* G. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?

☐ Yes ☒ No

* H. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

☐ Yes ☒ No

* I. Has the applicant, managing employees, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

☐ Yes ☒ No

* J. Has the applicant, managing employees, owners, or agent sever been found to have violated federal or state laws, rules, or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any publicly funded federal or state health care or health insurance program and been sanctioned accordingly; or ever been directly or indirectly affiliated with a provider or supplier that had its Medicare, Medicaid, or CHIP billing privileges denied or revoked?

☐ Yes ☒ No

* K. Has the applicant, managing employees, owners, or agents ever been convicted of an offense against the law other than a minor traffic violation?

☐ Yes ☒ No

Previous

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

Next 10

Exhibit 28. Exclusion Sanction Information Page

| Step | Action |
|------|---|
| 1 | <p>Select Yes or No for each Exclusion Sanction question. When Yes is selected for a question, the Infraction/Conviction Dates section displays. Select Add to add an Infraction/Conviction Date.</p> <ul style="list-style-type: none"> 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. <p>Disclosure of adverse legal actions may not preclude participation with the NC Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the NC Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).</p> <ul style="list-style-type: none"> 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.

The screenshot shows the 'Review Application' page. At the top, there is a title bar with 'Review Application' and icons for print, font size, and help. Below the title bar, a legend indicates that an asterisk (*) denotes a required field. The main content area is divided into three sections: 'ELECTRONIC SIGNATURE - EMAIL CONFIRMATION', 'REVIEW APPLICATION', and 'ASSIGN APPLICATION TO OFFICE ADMINISTRATOR'. The first section contains instructions about confirming the email address and a link to the 'Basic Information page'. The second section contains instructions about reviewing the application in Adobe PDF format and a button labeled 'Review Application' (callout 2). The third section contains instructions about assigning the application to the Office Administrator (OA) and a button labeled 'Assign Application to OA' (callout 3). At the bottom, there are navigation buttons for 'Previous', 'Next', 'Save Draft', and 'Delete Draft'. A footer note states that PDF documents require the free Adobe Reader to view and print.

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 logged-in user is the ES user.

3.31 STATUS AND MANAGEMENT PAGE

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 additional 10 days. If the correct information is not received the third time, the application will be abandoned and the provider will have to resubmit the application. If no documentation is received 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

AA Help

Legend

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

1

SUBMITTED APPLICATIONS

Below is the status of applications you have submitted.

If status is Payment Pending, we have received initial confirmation from Paypoint that your payment was confirmed; it may take up to 48 hours to verify the payment. If status is Pay Now, your NC Application Fee payment was not made or failed; click Pay Now to make payment.

If status of the application is in Payment Pending, Returned, or In Review, you can upload supporting documentation by clicking the Upload Documents hyperlink.

RECORD RESULTS

| NPI/Atypical ID | Name | DBA Name | Application Type | Submit Date | Status |
|-----------------|------|----------|--------------------------------|-------------|--|
| | | | 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 Complete |
| | | | MANAGE CHANGE REQUEST | 10/26/2018 | Withdrawn |
| | | | MANAGE CHANGE REQUEST | 10/09/2017 | Manage Change Request Complete |
| | | | ENROLLMENT | 08/09/2017 | Withdraw, Upload Documents - In 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 Complete |
| | | | ABBREVIATED METHOD OF CLAIM BI | 03/07/2017 | Manage Change Request Complete |
| | | | ABBREVIATED METHOD OF CLAIM BI | 01/13/2017 | Manage Change Request Complete |
| | | | ABBREVIATED METHOD OF CLAIM BI | 12/21/2016 | Manage Change Request Complete |
| | | | MANAGE CHANGE REQUEST | 11/09/2016 | Manage Change Request Complete |
| | | | ABBREVIATED METHOD OF CLAIM BI | 11/04/2016 | Manage Change Request Complete |
| | | | RE-VERIFICATION | 10/20/2016 | Withdrawn |
| | | | ABBREVIATED EFT MANAGE CHANGE | 10/17/2016 | Manage Change Request Complete |
| | | | MANAGE CHANGE REQUEST | 08/19/2016 | Withdrawn |
| | | | RE-VERIFICATION | 06/15/2016 | Withdrawn |
| | | | ENROLLMENT | 01/14/2016 | Approved |
| | | | RE-VERIFICATION | 12/07/2015 | Withdrawn |

2

RE-ENROLL

NO DATA FOUND

3

MANAGE CHANGE REQUEST

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

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

| Select | NPI/Atypical ID | Name | DBA Name | ZIP Code | Begin Date | Status |
|-----------------------|-----------------|------|----------|----------|------------|--------|
| <input type="radio"/> | | | | | | Active |
| <input type="radio"/> | | | | | | Active |
| <input type="radio"/> | | | | | | Active |
| <input type="radio"/> | | | | | | Active |

Update

4

RE-VERIFICATION

NO DATA FOUND

5

MAINTAIN ELIGIBILITY

NO DATA FOUND

6

FINGERPRINTING REQUIRED

NO DATA FOUND

6

SAVED APPLICATIONS

Please remember that your application must be submitted to the State within 90 days of the date it was created. If not completed within 90 days, the incomplete application will be deleted.

| Select | NPI/Atypical ID | Name | DBA Name | ZIP Code | Application Type | Application Create Date | Last Saved |
|-----------------------|-----------------|------|----------|----------|-----------------------|-------------------------|------------|
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 09/14/2021 | 09/14/2021 |
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 08/10/2021 | 08/10/2021 |
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 03/24/2021 | 07/21/2021 |
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 07/21/2021 | 10/20/2021 |
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 06/18/2021 | 10/13/2021 |
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 10/20/2021 | 10/20/2021 |
| <input type="radio"/> | | | | | MANAGE CHANGE REQUEST | 11/03/2021 | 11/03/2021 |

Exhibit 30. Status and Management Page

| Step | Action |
|------|---|
| 1 | <p>Submitted Applications: Allows the ES user to view the status of a submitted provider enrollment application.</p> <ul style="list-style-type: none"> 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. Pynt 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. <p>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.</p> <p>The Upload Documents hyperlink is present if the application is in one of the following statuses: In Review, Returned, and Payment Pending. Selecting this hyperlink takes the ES user to the Upload Documents page.</p> |
| 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. |

This Page Intentionally Left Blank

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

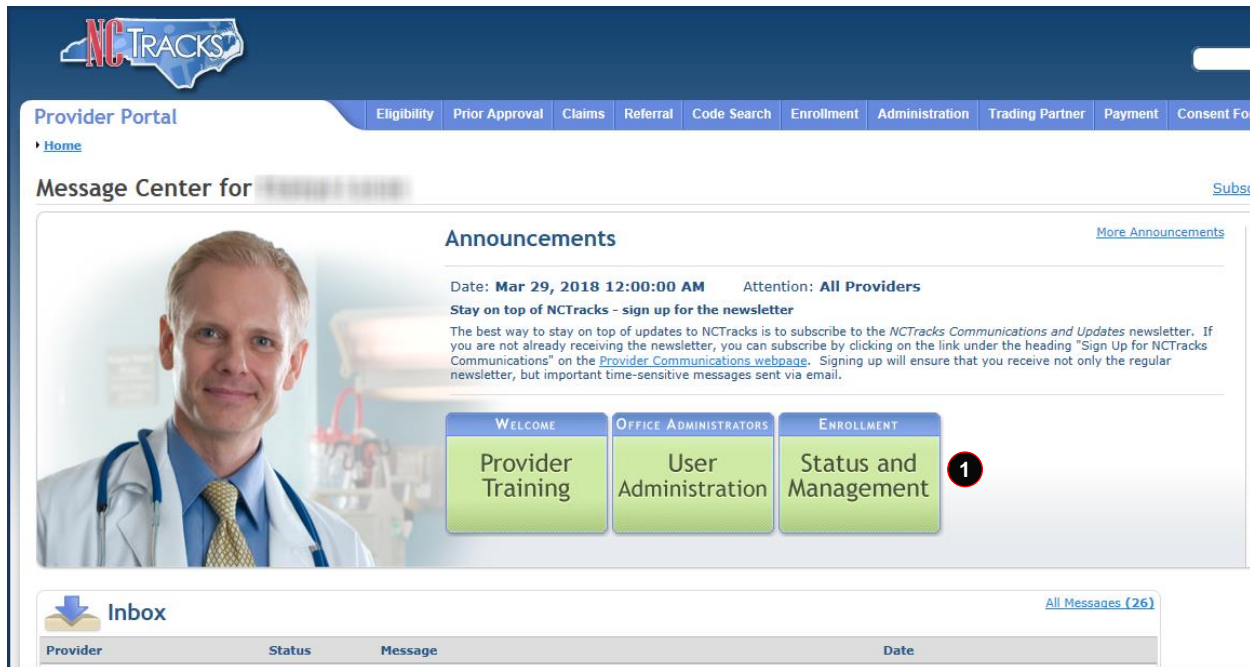


Exhibit 31. Provider Portal Home Page

| 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 CHANGE REQUEST

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

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

| Select | NPI/Atypical ID | Name | DBA Name | ZIP Code | Begin Date | Status |
|----------------------------------|-----------------|-----------------------|----------|------------|------------|--------|
| <input type="radio"/> | 412041038 | DR. JEFFREY L. HARRIS | | 27502-1216 | 01/01/2015 | Active |
| <input type="radio"/> | 0000000000 | DR. JEFFREY L. HARRIS | | 27502-1216 | 01/01/2015 | Active |
| <input checked="" type="radio"/> | 0000000000 | DR. JEFFREY L. HARRIS | | 28403-6062 | 02/01/2005 | Active |
| <input type="radio"/> | 0000000000 | DR. JEFFREY L. HARRIS | | 27502-1216 | 01/01/2015 | Active |
| <input type="radio"/> | 0000000000 | DR. JEFFREY L. HARRIS | | 27502-1216 | 01/01/2015 | Active |

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

Health / Benefit Plan Selection

* Indicates a required field

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

Legend

CURRENT STATUS

| Health Plan | Health Plan Status | Benefit Plan | Benefit Plan Status | Effective Date |
|---------------|--------------------|--|---------------------|----------------|
| TITLE NCIX | ACTIVE | | | 03/01/2013 |
| TITLE NCXI | TERMINATED | | | 03/13/2013 |
| PUBLIC HEALTH | ACTIVE | | | 03/01/2013 |
| | | Infant Toddler | ACTIVE | 03/14/2013 |
| | | Sickle 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: <ul style="list-style-type: none"> • Title NCXIX – Medicaid • Public Health • Rural Health |
| 2 | Health Plan Status – The provider's current status in the health plan: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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

1

★

Will you only be serving 0-3 population for behavioral health services?

☐ Yes
☐ No

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 *Add/Reinstate Health Plan Option(s)* choice.

1 * Update Type: Remove Health/Benefit Plan(s)

2 * Would you like to remove **TITLE NCXXIX** End-date Info Plans?

☒ Yes ☐ No

3 * End Date: mm/dd/yyyy

4 * Reason for ending coverage:

Comments:

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

☐ Yes ☐ 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?

☐ Yes ☐ No

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

| Step | Action |
|------|---|
| 1 | Update Type: Select one of the following: <ul style="list-style-type: none"> 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. |

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 CHAPEL HILL RD

Service Location Name: [Text Box]
Office Phone #: [Text Box] Office Fax #: [Text Box]

Address

Address Line 1: [Text Box]
Address Line 2: [Text Box]
City: **DURHAM**
State: **NORTH CAROLINA**
ZIP Code: **27707-1149** County: **DURHAM**
Begin Date: [Text Box] End Date: [Text Box]

Servicing Counties **DURHAM**

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 . |

Service Locations

SERVICE LOCATION 2 - 1803 CHAPEL HILL RD

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

Service Location Name:

* Office Phone #: (919) 555-8500 ext. Office Fax #: (000) 000-0000

Address

Address Line 1:

Address Line 2:

* City: DURHAM

State: NORTH CAROLINA

* ZIP Code: 27707-1149 County:

Begin Date: End Date:

☒ Re-instate **1**

* New Begin Date: mm/dd/yyyy **2**

Servicing Counties

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

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

3

Exhibit 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.

SERVICE LOCATION 3 - 403 E MAIN ST

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

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: Durham

Begin Date: 03/01/2013

1 ☒ End Date It

2 * End Date: 03/18/2013

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

3 **Save**

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 | | |
|-------------------|----------|-------------|
| Select | Location | Form Status |
| | | ✓ Complete |
| | | ✓ Complete |

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

Edit Location

Taxonomy Classification

SCHOOL BASED HEALTH CENTER

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

☐ Yes ☒ No

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

TYPE, CLASSIFICATION AND AREA OF SPECIALIZATION

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

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

Provider Type: HOSPITALS

Classification: General Acute Care Hospital

Area of Specialization: None

1

2 Begin Date: 03/14/2013 End Date: 03/15/2013

3 Status: ENDDATED

4

Reason Code: Voluntary Termination. No lon

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: <ul style="list-style-type: none"> • 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.

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.

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 [Section 3.0, New Enrollment – Enrollment Specialist](#).

Community Care of North Carolina/Carolina ACCESS

* indicates a required field

Legend

| Select | Location | Form Status |
|--------|----------|-------------|
| | | Complete |

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

Edit Location

Community Care of North Carolina/Carolina ACCESS

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

COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS

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

1 CCNC/CA CONTACT PERSON

* Last Name: * First Name:

Middle Name: Suffix: -- Select One --

* Office Phone #: ext. Other Phone #: (000) 000-0000 ext.

Office Fax #: (000) 000-0000 * Contact Email:

2 CCNC/CA Begin Date: 04/01/2013 **3** ☐ End Date It:

Save Location

4

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

Previous Next

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

EFT Account Information

* indicates a required field

Legend

1 **CURRENT FINANCIAL INSTITUTION ACCOUNT INFORMATION**

Financial Institution Name: Account Number: *****

2 **UPDATE FINANCIAL INSTITUTION INFORMATION**

* Do you wish to update your Electronic Funds Transfer Financial Institution information?

Your new EFT Account Information will be effective upon submission. You are responsible for contacting your financial institution to receive information regarding the delivery of the CACH CORE information required to reassociate your payments with the electronic remittance advice (ERA). You may also visit the CAQH CORE website for more information (CAQH.org).

☒ Yes ☐ No

* Routing Number: Account Number: * Account Number Confirmation:

* Account Type: -- Select One --

* Financial Institution Name:

Financial Institution Address

* Address Line 1: Address Line 2:

* City: * State: -- ZIP Code:

3 **Verify Address**

Previous Next

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

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:

| |
|--|
| |
| |
| |

This Page Intentionally Left Blank

5.0 Re-enrollment Application

5.1 STATUS AND MANAGEMENT PAGE

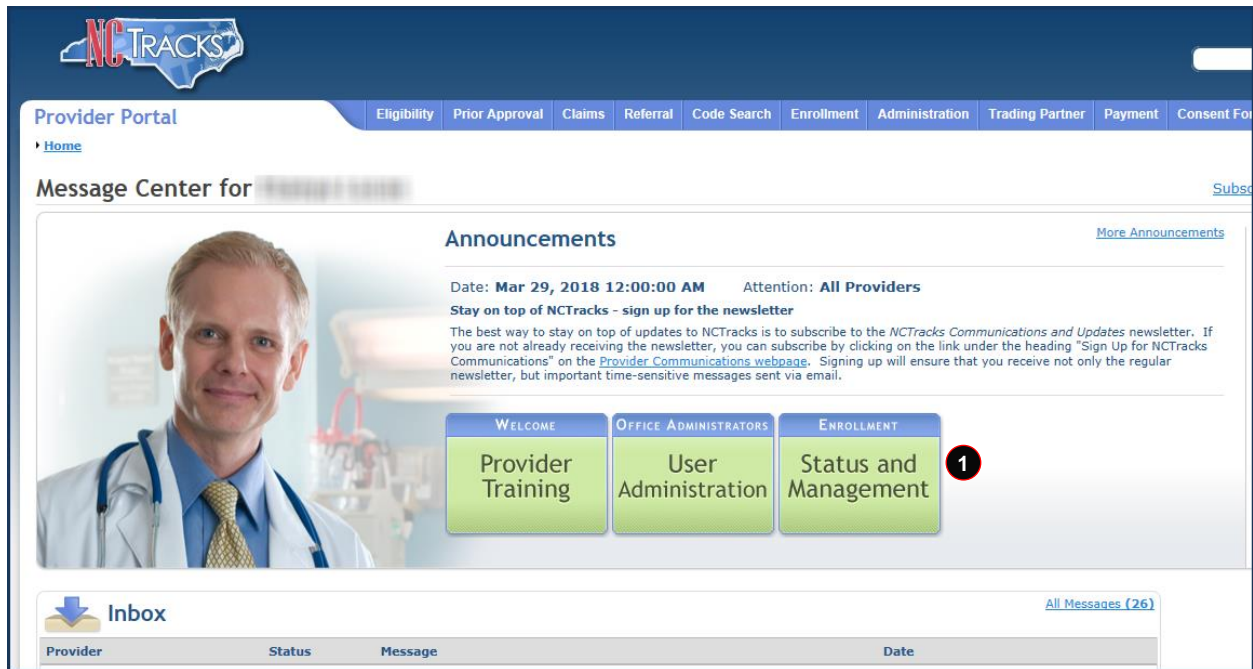


Exhibit 44. Provider Portal Home Page

| 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.

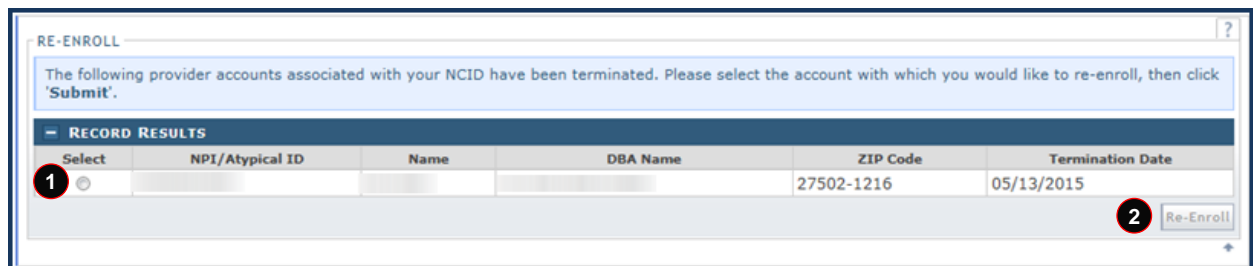


Exhibit 45. Status and Management Page: Re-enroll Section

| 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 . |

6.0 Re-verification Application

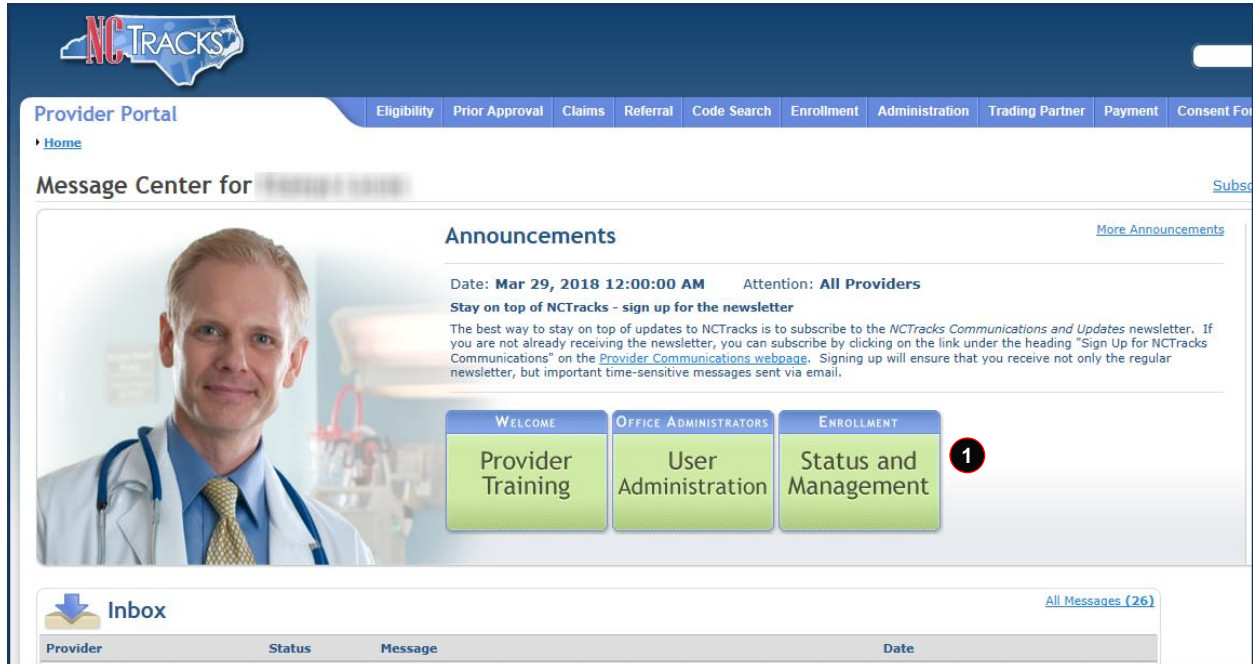


Exhibit 46. Provider Portal Home Page

| 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.

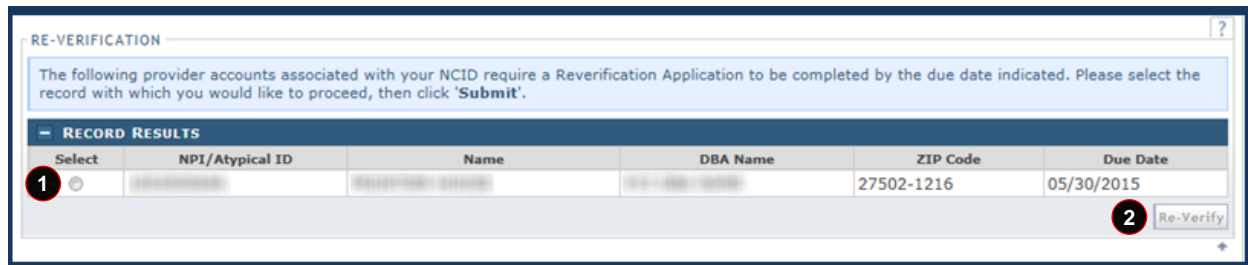


Exhibit 47. Status and Management Page: Re-verification Section

| 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.

Individual Basic Information

* indicates a required field

AA Help

Legend

IDENTIFYING INFORMATION

* Last Name:

* First Name:

Middle Name:

Suffix: -- Select One --

(Enter your full middle name)

* Date of Birth:

* SSN:

* Gender:

* NPI: 0000000000

* Email:

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

EMPLOYER IDENTIFICATION NUMBER (EIN)

* Will your income be reported to an EIN?

☒ Yes ☐ No

* EIN:

* DBA Name:

* Years Doing Business Under This Name:

RENDERING/ATTENDING ONLY PROVIDER

* Are you a Rendering/Attending Only provider?

☐ Yes ☐ No

OWNERSHIP INFORMATION

* Business Type: -- Select One --

OFFICE ADMINISTRATOR (AUTHORIZED INDIVIDUAL)

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

* User ID (NCID):

* Last Name:

* First Name:

Suffix: -- Select One --

(Enter your full middle name)

* Contact Email:

* SSN:

* Office Phone #:

Office Fax #:

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

EFFECTIVE DATE REQUESTED

The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment may not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received and may not precede, as applicable, the current date of your licensure or the current date of your letter of endorsement.

Note: CCNC/CA participation effective date may not be retroactively requested.

* Effective Date:

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

Please be sure to complete all required fields with content.

Next »

Exhibit 48. Re-Verification Application – Individual Provider Page

Re-Verification Application - Organization Basic Information

* Indicates a required field

Organization Name:

EIN:

* Email:

NPI/Atypical Provider ID:

* Month of Fiscal Year End:

DOING BUSINESS AS (DBA)

* Do you operate under a trade or company name?

☒ Yes ☐ No

DBA Information

* DBA Name:

* Years Doing Business Under This Name:

OWNERSHIP INFORMATION

* Business Type:

REGISTERING WITH NC SECRETARY OF STATE

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

Secretary of State ID #:

OFFICE ADMINISTRATOR (AUTHORIZED INDIVIDUAL)

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

* User ID (NCID):

* Last Name:

Middle Name:

(Enter your full middle name)

* First Name:

Suffix:

* Contact Email:

SSN:

* Office Phone #: ext.

Office Fax #:

* Is this contact person an Owner or Managing Employee?

☐ Owner ☐ Managing Employee

Next >

Save Draft

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.

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.

Re-Verification Application - Ownership Information

* Indicates a required field

Legend

Do you have one or more Shareholders/Partners with 5% 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 the full legal name of the individual, and the individual does not have a middle name.

Address Line 1 :
Address Line 2 :
City :
State :
ZIP Code :

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

Edit

BUSINESS

BUSINESS

BUSINESS

BUSINESS

BUSINESS

Add Shareholder/Partner

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

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

Previous Next

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

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

SHAREHOLDER/PARTNER INFORMATION

INDIVIDUAL (AUTHORIZED INDIVIDUAL)

Last Name : First Name :
Middle Name : Suffix :
SSN :
Gender :
Email : Phone Number :

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

Address Line 1 :
Address Line 2 :
City :
State :
ZIP Code :

Relationship to Another Disclosing Person : **None** Percent of Ownership/Control : **100 %**
Interest :
Begin Date : End Date :

Edit

Add Shareholder/Partner

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

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

Previous Next

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

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.

Re-Verification Application - Agents and Managing Employees

* Indicates a required field

Legend

RELATIONSHIP DISCLOSURE

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, managing employee, director, board member, and Electronic Funds Transfer (EFT) authorized individual.
Failure to provide the required information may result in a denial for participation.

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

Managing Relationships

Please add all managing relationships below.

1

MANAGING RELATIONSHIP - (MANAGING CONTACT)

MANAGING RELATIONSHIP - (AUTHORIZED INDIVIDUAL MANAGING CONTACT)

Add Relationship

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

* Last Name:

* First Name:

Middle Name:

(Enter your full middle name)

Suffix:

-- Select One --

* Date of Birth:

mm/dd/yyyy

* SSN:

* Email:

* Phone Number:

(000) 000-0000

* Business Relationship:

-- Select One --

* Relationship to Another Disclosing Person:

-- Select One --

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

* Address Line 1:

Address Line 2:

* City:

* State:

--

* ZIP Code:

00000-0000

2

Verify Address

Add

Clear

Previous

Next

Save Draft

Delete Draft

Exhibit 53. Agents and Managing Employees Page

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

Agents and Managing Employees

* indicates a required field

Legend

RELATIONSHIP DISCLOSURE

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, managing employee, director, board member, and Electronic Funds Transfer (EFT) authorized individual.
Failure to provide the required information may result in a denial for participation.

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

Managing Relationships

Please add all managing relationships below.

MANAGING RELATIONSHIP (AUTHORIZED INDIVIDUAL MANAGING CONTACT)

3

Last Name : First Name :
Middle Name : Suffix :
SSN : Phone Number :
Email :
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:

4

Edit

Add Relationship

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

■ indicates a required field

Legend

ACCREDITATIONS

Add Accreditation

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

Accreditation Type: -- Select One --

Accreditation #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

Add Clear

CERTIFICATIONS

+ CERTIFICATION - CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

+ CERTIFICATION - DRUG ENFORCEMENT AGENCY (DEA)

Add Certification

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

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

Certification Type: -- Select One --

Certifying Entity: -- Select One --

State: NORTH CAROLINA

Certification #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

Add Clear

LICENSES

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

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

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

License Agency: STATE MEDICAL BOARD

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

State: NORTH CAROLINA

License #:

Effective Date: 07/19/1997

Expiration Date: 06/30/2022

Edit

Add License

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

License Agency: -- Select One --

License Type: -- Select One --

State: NORTH CAROLINA

License #:

Effective Date: mm/dd/yyyy

Expiration Date: mm/dd/yyyy

Add Clear

Previous Next

Save Draft Delete Draft

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). |

| 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.

Provider Supplemental Information Print AA Help

* indicates a required field Legend

1 WORK HISTORY ?

Enter your work history as a health professional for the past 5 years. Work history prior to 5 years ago is not needed. If there is a gap in your employment of more than six months, please upload documentation clarifying the gap upon application submission.

Add Work History

* Company Name: * Job Title:
 * Start Date: * End Date:

2 EDUCATION ?

Enter your highest level of education completed.

Add Education History

* School Name: * Degree:
 * Start Date: * Graduate Date:

3 CURRENT MALPRACTICE INSURANCE COVERAGE ?

Medical providers should carry professional liability coverage, often called malpractice insurance. This insurance covers your exposure to liability arising from your profession, including allegations of malpractice. Liability insurance offers essential financial protection because a malpractice suit can be brought against you at any time after you have seen a patient.

Enter your current malpractice insurance coverage. Upon submission of the application, upload a copy of the insurance face sheet from the malpractice carrier or a copy of the federal tortletter or an attestation from the practitioner of federal tort coverage.

* Do you have malpractice insurance or are you covered under a federal tort?
☐ Yes ☐ No

Please be sure to complete all required fields with valid content. **4**

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

| Step | Action |
|------|--|
| 1 | <p>In the Work History section of the Provider Supplemental Information page, enter your work history as a health professional:</p> <ul style="list-style-type: none"> • Company Name – Employer name • Job Title – Position/job title • Start Date – Start date of the job title at this company • End Date – End date of the job. If you still hold this job title at this company, enter 12/31/9999. <p>If there is a gap in the Individual provider's work history of 6 months or more, the provider is required to upload written documentation explaining any gaps that occurred in the past 5 years.</p> |
| 2 | <p>In the Education section, enter your Education information:</p> <ul style="list-style-type: none"> • School Name – School or institution name • Degree – Highest degree • Start Date – Date started at the school or institution • Graduation Date – Date graduated from the school with this degree |
| 3 | <p>In the Current Malpractice Insurance Coverage section, enter/select the following:</p> <ul style="list-style-type: none"> • Do you have malpractice insurance or are you covered under a federal tort? – Select Yes if you have malpractice insurance or are covered under a federal tort • Malpractice Type – Select the type of malpractice coverage • 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.

Exhibit 57. Federal Requirements Page

| Step | Action |
|------|---|
| 1 | <p>Federal Site Visit: Have you completed the Federal site visit for this site to NC Medicaid, another state or Medicare?</p> <ul style="list-style-type: none"> Select NO if you have not completed a Federal site visit for this location with either another state or Medicare. Select MEDICARE if completed with Medicare. Select OTHER STATE if completed for another state Medicaid program. Note: If you select NO, Public Consulting Group (PCG) will contact you after the application has been submitted to set up the site visit. If you select MEDICARE, CSRA will confirm the site visit completion with Medicare. If you select OTHER STATE, you are required to upload proof of completion as part of the application submission. |
| 2 | Other State: If applicable, select the state. |
| 3 | <p>Federal Fee: Have you paid the Federal Fee for this site to NC Medicaid, another state or Medicare?</p> <ul style="list-style-type: none"> Select NO if you have not paid a Federal Fee for this location with either another state or Medicare. Select MEDICARE if paid to Medicare. Select OTHER STATE if completed for another state Medicaid program. Note: If you select NO, upon submission of this application, you will be directed to PayPoint to pay the fee. |

| Step | Action |
|------|--|
| | <ul style="list-style-type: none"> If you select MEDICARE, CSRA will confirm the payment was made with Medicare. If you select OTHER STATE, you are required to upload proof of payment as part of the application submission. 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

Re-Verification Application - Exclusion Sanction Information

* Indicates a required field

Legend

**WARNING!!! FAILURE TO DISCLOSE WILL RESULT IN AN APPLICATION DENIAL AND CAUSE ALL NON-DHH HEALTH PLANS TO TERMINATE. RE-ENROLLMENT WILL BE REQUIRED.**

EXCLUSION SANCTION INFORMATION

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

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

For each question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.

* A. Has the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony, or entered into a pre-trial agreement for a felony?

☒ Yes ☐ No

Please add up to 5 Infraction/Conviction Dates.

INFRACTION/CONVICTION DATES

Infraction/Conviction Date

01/05/2009

mm/dd/yyyy

Add Clear

* B. Has the applicant, managing employees, owners, or agents ever had disciplinary action taken against any business or professional license held in this or any other state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?

☐ Yes ☒ No

* C. Has the applicant, managing employees, owners, or agent sever been denied enrollment, been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state; or ever been directly or indirectly affiliated with a provider or supplier that has been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or health insurance program in any state?

☐ Yes ☒ No

* D. Has the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state; or ever been directly or indirectly affiliated with a provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state?

☐ Yes ☒ No

* E. Has the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal Agency or Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?

☐ Yes ☒ No

* F. Does the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid; or ever been directly or indirectly affiliated with a provider or supplier that has uncollected debt owed to Medicare, Medicaid, or CHIP?

☐ Yes ☒ No

* G. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?

☐ Yes ☒ No

* H. Has the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

☐ Yes ☒ No

* I. Has the applicant, managing employees, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

☐ Yes ☒ No

* J. Has the applicant, managing employees, owners, or agent sever been found to have violated federal or state laws, rules, or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any publicly funded federal or state health care or health insurance program and been sanctioned accordingly; or ever been directly or indirectly affiliated with a provider or supplier that had its Medicare, Medicaid, or CHIP billing privileges denied or revoked?

☐ Yes ☒ No

* K. Has the applicant, managing employees, owners, or agents ever been convicted of an offense against the law other than a minor traffic violation?

☐ Yes ☒ No

Previous

Next

Save Drafts Delete Drafts

Exhibit 58. Exclusion Sanction Information Page

| Step | Action |
|------|--|
| 1 | <p>Select Yes or No for each Exclusion Sanction question. When Yes is selected for a question, the Infraction/Conviction Dates section displays.</p> <p>For each question answered Yes, 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.</p> <p>Disclosure of adverse legal actions may not preclude participation with the NC Medicaid Program; however, full and accurate disclosure is critical to determining an applicant's eligibility for participation with the NC Medicaid Program and is required by federal law (see 42 CFR Chapter IV, part 455, Subpart B).</p> <p>Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.</p> |

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.

Review Application

* indicates a required field

Legend

ELECTRONIC SIGNATURE - EMAIL CONFIRMATION

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

1 Contact Email:

REVIEW APPLICATION

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

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 submit the application, select the Assign Application to OA button.

3 Assign Application to OA

« Previous

Please be sure to complete **4** required fields with valid content. Next »

Save Draft Delete Draft

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

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]).

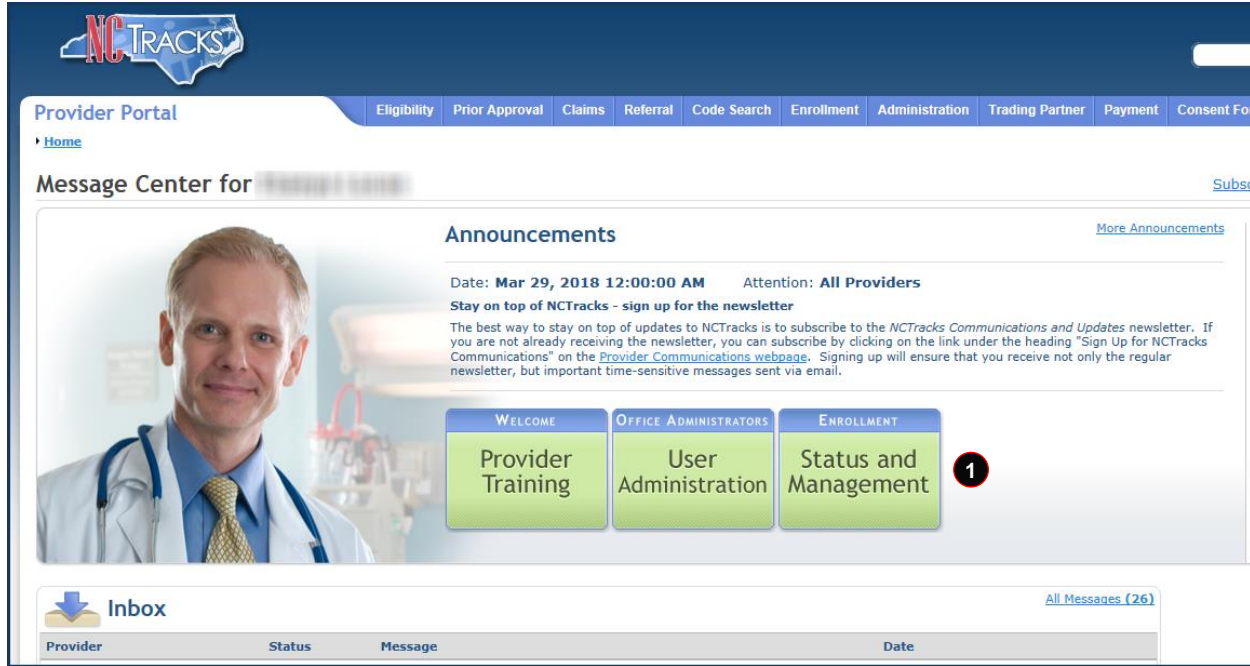


Exhibit 60. Provider Portal Home Page

| 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.

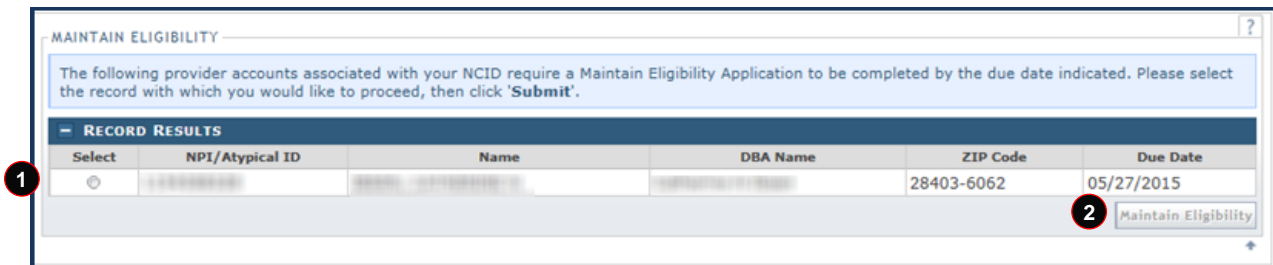


Exhibit 61. Status and Management Page: Maintain Eligibility Section

| 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 [Section 6.0](#).

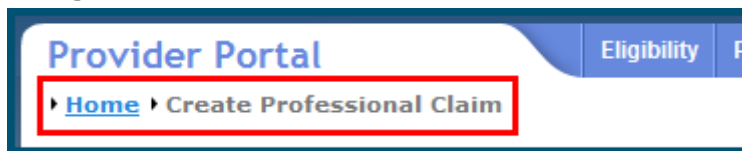
Once the Maintain Eligibility application is submitted, the provider record will be updated to indicate that the provider wishes to remain active. **Note:** The submitted Maintain Eligibility application will appear on the **Status and Management** page in the **Submitted Applications** section with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

Addendum A. Help System

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

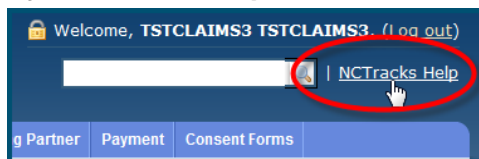
- Navigational breadcrumbs
- System-Level Help – Indicated by the “NCTracks Help” link on each screen
- Screen-Level Help – Indicated by the “Help” link above the Legend
- Legend
- Data/Section Group Help – Indicated by a question mark (?)
- Hover-over or Tooltip Help on form elements

Navigational Breadcrumb



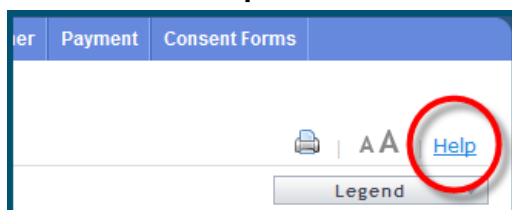
A breadcrumb trail is a navigational tool that shows the path of screens that the user has visited from the home screen. This breadcrumb consists of links so the user can return to specific screens on this path.

System-Level Help



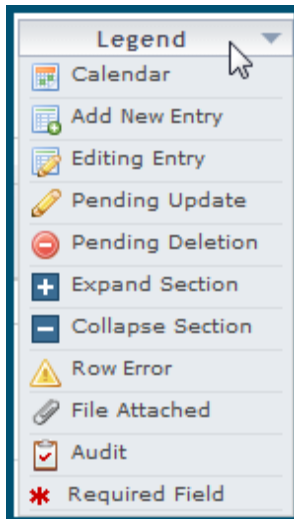
The System-Level Help link opens a new window with the complete table of contents for a given user's account privileges. The System-Level Help link, “NCTracks Help”, will display at the top right of any secure portal screen or web application form screen that contains Screen-Level and/or Data/Section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

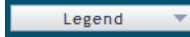
Screen-Level Help



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



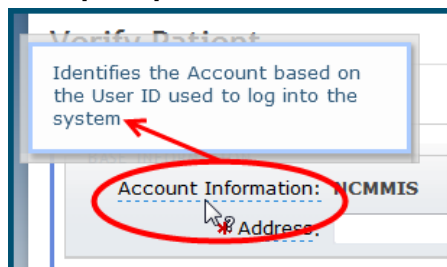
A legend of all helpful icons is presented on screens as needed to explain the relevant meanings. This helps the user become familiar with any new icon representations in context with the form or screen as it is used. Move the mouse over the Legend icon  to open the list.

Data / Section Group Help

A screenshot of a 'Data / Section Group Help' modal window. The window contains several input fields for patient information, including Recipient ID, SSN, Date of Birth, Date of Service, and From/To dates. A red circle highlights a question mark icon in the top right corner of the modal, indicating that clicking it will open the help information for the selected data group.

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



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.