



JOB AID Re-verification

OVERVIEW

This Job Aid provides foundational information on the purpose and requirements for provider Re-verification and guides the user through the steps for completing the Re-verification process through NCTracks.

RE-VERIFICATION PURPOSE

The Re-verification process ensures the provider record is accurate and allows a criminal background check for all owners and managing relationships associated with the provider record.

The Code of Federal Regulations, Title 42, Part 455.414 requires the state Medicaid agency to re-validate the enrollment of all providers regardless of the provider type at least every 5 years. Therefore, NC Medicaid and North Carolina Health Choice (NCHC) providers are required to complete the Re-verification process every 5 years.

In addition to the criminal background check, a set of fingerprints may be required from each Individual provider and any owner that has a 5% or more direct or indirect ownership in the provider/entity. Fingerprint requirements are based on the provider type risk level. Only the Individual provider and owners with 5% or more ownership for certain high-risk provider types will be required to upload fingerprint information. There may be times that Program Integrity requests that CSRA obtain fingerprint submissions from any provider type.

A site visit by Public Consulting Group (PCG) may also be required.

RE-VERIFICATION FEE

- A \$100 North Carolina Application Fee is required from Individual providers.
- A \$100 North Carolina Application Fee is also required from Organizations and Atypical Organizations if active in Medicaid and/or NCHC.
 - The Federal Fee of \$599 will be required per location when one or more Moderate or High Risk taxonomy codes are active. (Please refer to the Provider Permission Matrix.)

Note: The NC Application Fee is non-refundable if your application is denied.

In the event that the enrolling provider type requires fingerprinting, NCTracks will not require any additional fees. However, the local fingerprinting agency may require a fee for their service. It is recommended that the agency be contacted to confirm.

WHO MUST COMPLETE RE-VERIFICATION?

Actively enrolled Individual, Organization, and Atypical Organization providers are required to complete the Re-verification application.

Note: The Office Administrator (OA) or the Enrollment Specialist (ES) for the provider can complete the Re-verification process. However, the OA is the only person who can submit the Re-verification application.





RE-VERIFICATION EXCEPTIONS

Exceptions for providers who do not need to complete Re-verification are:

- Providers enrolled with a Division of Mental Health (DMH) only health plan.
- Providers who are time-limited enrolled such as out-of-state (OOS) Lite providers. Be aware that OOS Lite providers must continue to complete the enrollment process every 365 days.
- Providers with an active 302R00000X Health Maintenance Organization or 305R00000X Preferred Provider Organization taxonomy code.
 - Newly enrolled providers do not need to complete Re-verification for 5 years.

RE-VERIFICATION LETTER

When a provider is due to complete a Re-verification application, a Re-verification Letter will be sent to the provider's NCTracks Message Center Inbox 70 days before the due date. The Re-verification Letter instructs the provider to navigate to their **Status and Management** page and electronically complete and submit the Re-verification application.

If a Re-verification application is not submitted, reminder letters will be sent to the provider's Message Center Inbox at 50 days, 20 days, and 5 days prior to the provider's Re-verification due date.





DATE

NAME ADDRESS CITY< STATE< ZIP

NPI/Atypical Provider ID:

Provider Name:

Dear :

We are verifying and updating North Carolina DHHS provider enrollment records for NPI/Atypical Provider It is important that you submit the Re-verification Application on or before ID to avoid suspension and/or termination of your NPI/Atypical Provider ID. If you serve Carolina ACCESS or ACCESSII enrollees they will be reassigned if your NPI/Atypical Provider ID is terminated.

As outlined in your North Carolina DHHS Provider Administrative Participation Agreement, you must keep your provider information (ownership, licensure, affiliations, address, contact information) updated. Please ensure your information is correct before submitting the Re-verification Application. Updating your ownership, agents, managing employees, federal fee and site visit, and exclusion sanction information can be done within the Reverification Application If you need to update any other information, your Office Administrator should follow these steps before completing the Re-verification Application:

- Login to the NCTracks Secure Provider Portal (http://www.nctrackmc.gov)
- 2. Navigate to the Status and Management Page
- 3. Your NPI/AtypicalID will be located in the Manage Change Request Section
- 4. Complete and submit the Manage Change Request Application

After the Manage Change Request is approved, then complete the Re-verification Application.

To update your ownership, agents, managing employees, federal fee and site visit, exclusion sanction information within the Reverification application, your Office Administrator should:

- Login to the NCTracks Secure Provider Portal (http://www.nctracksnc.gov)
- 2. Navigate to the Status and Management Page
- 3. Your NPI/AtypicalID will be located in the Re-verification Section
- 4. Select the NPI/Atypical ID and click Re-verify 5. Complete and submit the Re-verification Application

MORE INFORMATION

- Please visit the NCTracks website (http://www.nctracksnc.gov) for more informationabout the DHHS Programs, Claims, CCNC/CA, and other provider information.
- It is your responsibility as a provider to keep your provider information up to date. To update your providerinformation login to NCTracks at (http://www.nctracksnc.gov) and submit a Manage Change Request.

If you have any questions regarding this notice or need additional assistance, please contact the CSRA Call Center at 800-688-6696 or NCTracksprovider@ctrackscom

Sincerely.

NCTracks Operations Center





SUSPENSION LETTER

If the Re-verification application is NOT submitted 70 days prior to the due date indicated on the initial Re-verification notification letter, the provider's NC Medicaid, NCHC, Division of Public Health (DPH), and Office of Rural Health (ORH)/Migrant Health health plans will be suspended for 50 days.

A Re-verification Suspension Letter will be sent to the provider's Message Center Inbox. A hardcopy of the letter will also be sent by regular U.S. postal mail.

The provider's claims will pend if their record is suspended.

Claims will continue to pend until the Re-verification application is submitted by the provider.

[Curre	ent Date]
Provi	der Address Line 21
[Provi	der Address City], [Provider Address State] [Provider Address Postal Code]
NPI/A Provid	typical Provider ID: XXXXXXXXXXX Jer Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Dear [Salutation],
Our re	cord indicates that you have not submitted a Re-verification Application.
Yourd	aims are now suspended.
To con verific MM/D	ntinue participation in the North Carolina DHHS programs, you must complete the Re- ation Application by MM/DD/YYYY. If you submit your Re-verification Application by D/YYYY, your suspended claims will be released for processing.
Your	Office Administrator should follow these steps to complete the re-verification application:
1.	Login to the NCTracks Secure Provider Portal (http://www.nctracks.nc.gov)
2.	Navigate to the Status and Management Page
3.	Your NPI/Atypical ID will be located in the Re-verification Section
4.	Select the NPI/Atypical ID and click Re-verify
5.	Complete and submit the Re-verification Application
IF THE	S REQUEST IS NOT COMPLETED BY MM/DD/YYYY, YOUR NPI/ATYPICAL ID WILL RMINATED AND A RE-ENROLLMENT WILL BE REQUIRED TO PARTICIPATE IN OHHS PROGRAMS.
If you	have any questions regarding this notice or need additional assistance, please contact the Call Center at 800-688-6696 or NCTracksprovider@nctracks.com





TERMINATION LETTER

The provider will be terminated from the NC Medicaid, NCHC, DPH, and ORH/Migrant Health health plans following 50 days of suspension.

An automated process will release "Pended" claims with dates of service prior to the Re-verification due date to continue to adjudicate. "Pended" claims submitted with dates of service during the suspension period will release and deny.

CERTIFIED MAIL [Current Date] [Correspondence Provider Address Line 1] [Provider Address Line 2] [Provider Address City], [Provider Address State] [Provider Address Postal Code] NPI/Atypical Provider ID: [Provider National Provider Identifier][Provider Atypical] Provider Name: [Provider Name] Re: DHHS Health Plan Termination Dear Provider Name, Your participation in the following DHHS health plan has been terminated: Health Plan: [Health Plan Identifier] Health Plan: [Health Plan Identifier]

SUPPORTING DOCUMENTATION REQUIRED

If during the credentialing process 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, but 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. If no documentation is received after the first 30-day notice or either of the 10-day notices, the application will be abandoned.





Date: NPI/Atypical Id: Provider Name: Reference Id:
Dear
Your application for DHHS participation submitted on is incomplete as submitted and cannot be processed for approval. Please submit the following required document(s) by :
Required Documents;
An electronic copy of the required documentation must be uploaded on the Provider Secure Portal Status and Management Page. Emailed, faxed or mailed documentation will not be accepted.
If you do not submit the required documents by , your application will be abandoned. If you have already passes your Re-verification Due Date, your health plans will be terminated and you will be required to re-enroll. If you have not already passed your re-verification Due Date, you must complete and submit a new Re-verification application and pau any applicable fees.
If you have any questions regarding this notice or need additional assistance, please contact the NCTracks Operations Center at <u>1-800-688-6696</u> or email the NCTracks Operations Center at <u>NCTracksprovider@nctracks.com</u> .
Sincerely. NCTracks Operations Center

Abandoned Re-verification applications will result in the termination of the provider's Medicaid, NCHC, DPH, and ORH/Migrant Health health plans if the current date is after the suspension date. If Medicaid, NCHC, DPH, and ORH/Migrant Health are the only active health plans on the provider's record, a Re-enrollment application will be required. If the current date is before the suspension date, the provider can resubmit the Re-verification application.





Subject: Abandoned Application

Your application submitted on MM/DD/YYYY has been abandoned because you did not submit the required documentation within 30/10 days.

For Re-verification Applications, print this paragraph: If you have already passed your Re-verification Due Date, your health plans will be terminated and you will be required to re-enroll. If you have not already passed your Re-verification Due Date, you must complete and submit a new Re-verification application and pay any applicable fees.

For Enrollment, Re-enrollment, and Manage Change Request Applications, print this paragraph: You must complete and submit a new application and pay any applicable fees.

If you have any questions regarding this notice or need additional assistance, please contact the NCTracks Operations Center 800-688-6696 or email the NCTracks Operations Center at NCTracksprovider@nctracks.com.

Sincerely, NCTracks Operations Center

Note: The OA/ES user will have access to the notification letters via the Message Center Inbox, as well as be provided a hyperlink on the **Status and Management** page to view the notification.

LOG IN TO NCTRACKS PROVIDER PORTAL







Step	Action
1	Open a supported Internet browser, such as Microsoft Internet Explorer version 11, Mozilla Firefox version 69 or 70, or Google Chrome version 77 or 78.
	Enter the following web address:
	https://www.nctracks.nc.gov/content/public/providers.html
	NCTracks will open in the Providers tab. Select NCTracks Secure Portal.
2	Enter your NCID as your User ID; then enter your Password.
	Note : If you do not have an NCID, you may sign up for one by selecting the NCID hyperlink on this page.
3	Select Log In.
	Passwords are case-sensitive. After three unsuccessful attempts, the user will be locked out; however, NCTracks will provide a contact number that the user can call for access assistance. Multi-Factor Authentication (MFA) is required. After the user enters the User ID and password, the second level authentication will be sent to the user's preferred method (Phone or Mobile App). For more information on the MFA registration process, refer to the "Provider Multi Factor Authentication Registration Process" Job Aid located in SkillPort.

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





COMPLETE THE RE-VERIFICATION PROCESS

Provider Portal Home Page

The step-by-step Re-verification process is completed from the **Status and Management** section of the NCTracks Provider Portal.

Note: The OA or someone who has been designated as the ES for the provider can complete Re-verification. However, the OA is the only person who can submit the Re-verification application.

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216 IRAC	2		I NCTracks Help
Provider Portal	er for	Eligibility Prior Approval Claims Referral Administration Payment Trading Partner Code Search Consent Form	subscription Preferences 🛱 A.A. Help
	A P	Announcements More Announcement Date: Nov 6, 2014 12:00:00 AM Attention: All Providers Stay on top of NCTracks - sign up for the sessilatter	Quick Links CONC/CA (Managed Care) Despiriment of Health and Human Services
1	251	The basit way to stay on top of updates to INCTracks is to subsorbe to the INCTracks Communications and Updates meetafater. If you are not already reasking the meetafater, you can subsorbe by Okicing on the link under the heading "Sign up for INCTracks Communications" on the <u>Provider Communications</u> , webpace. Signing up will ensure that you receive not only the regular meetafater, but important time sensitive messages sent via email.	Division of Health Service Regulation Division of Health Benefits DHB (Health Check)
4	2.	Provider Training Administration Status and Administration 2	DMH/DD/SAS Division of Public Health Office of Rural Health and
R	11/		Community Care Provider Training
Inbox		All Menneden (27)	
Provider	Status	Message Date	
	Read	PM16000-R0053 09/28/2015 01:32 pm	
	Read	PM16000-81145 09/22/2015 02:06 pm	
	Unread	PM16000-81145 09/22/2013 02:06 pm	

Step	Action
1	A Re-verification Letter is sent to the provider's NCTracks Inbox, alerting the provider that they need to complete the Re-verification application.
2	Select Status and Management.

The Status and Management page displays.

Status and Management Page

The **Status and Management** page allows the provider to manage their enrollment for the application process. Here you will find sections for Submitted Applications, Saved Applications, Manage Change Request, and Re-verification. Scroll down to the **Re-verification** section of the page.

Note: For more information on the sections of this page, refer to <u>Appendix A, Sections of the</u> <u>Status and Management Page</u>.





Status and Managem	ent				AAIH
 indicates a required field 					Legend
Nelcome to Provider Enro Nease choose from the options	llment Status and Manageme below to manage your enrollment :	ent status.			
SUBMITTED APPLICATIONS					
If status is Payment Pending the payment. If status is Pa If status of the application is hyperlink.), we have received initial confirma y Now, your NC Application Fee pa s in Payment Pending, Returned, o	ation from Paypoint that your p ayment was not made or failed; r In Review, you can upload su	ayment was confirmed; it may tal click Pay Now to make payment. pporting documentation by clickin	ce up to 48 hours g the Upload Docu	to verify uments
- RECORD RESULTS	News		Application Trees	Cubmit Data	Chabus
NP1/Atypical ID	Name	DDA Name	Manage Change Request	10/19/2015	Approved
			Re-verification	10/15/2015	Approved
			Manage Change Request	10/14/2015	Approved

The **Re-verification** section displays all National Provider Identifiers (NPIs) that are due for Re-verification under that particular OA.

record with y) provider accounts associated which you would like to procee	l with your NCID require a Rever	rification Application to be complet	ed by the due date indic	cated. Please select t
Calast	RESULTS	News	DBA Nama	ZID Cada	Due Dete
Select	NP1/Atypical ID	Name	DDA Name	ZIP Code	Due Date
2 200					

Step	Action
3	Select the line with the desired NPI.
4	Select Re-Verify.

The **Re-Verification Application – Organization** or **Re-Verification Application – Individual Provider** page displays.

This page presents specific information about you as an Organization or Individual provider. This information must match what is reported on your income tax return.





	RACKS				<u></u>	Welcome, (Log out)
						NCTracks Help
Provider Po	rtal	Eligibility Prior Approval Claims F	teferral Code Search <u>Enrollmer</u>	t Administration Payment Trading Partner	Consent Forms	
+ <u>Home</u> + <u>Provide</u>	r Enrollment) Online Pr	ovider Enrollment Ap				
Provider Enro	ollment	Re-Verification Applicati	on - Organization			
NOTE: Data is not a button is activated.	saved unless the 'Next'	indicates a required field				Legend 🔻
Contact CSKA Cal	I center -	Please click the 'Next' button to cont	inue the Re-Verification Applica	tion.		
		DENTIFYING INFORMATION				?
		Organization Name:				
		EIN:	101 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NPI/Atypical ID:		
						Next //
ЛОТО	ACKET					Welcome, (Log out)
464	ACRO					🔍 <u>NCTracks Help</u>
Provider Port		Eligibility Prior Approval Claims F	eferral Code Search Enrollme	nt Administration Trading Partner Payment	Consent Forms	Fraining
Home Provider E	nrollment + Online Provi	der Enrollment Ap			The second s	
Provider Enroll	ment	Re-Verification Applicati	on - Individual Pro	vider		
NOTE: Data is not say button is activated.	ved unless the 'Next'	✤ indicates a required field				Legend 👻
Contact CSRA Call of	enter 🗖	Please click the 'Next' button to contin	ue the Re-Verification Applicat	ion.		
		DENTIFYING INFORMATION				?
		Last Name:		First Name:	-	
		Middle Name:	-	Suffix:		
		Date of Birth:		SSN:	***_**	
		Gender:		NPI/Atypical ID:		
						5 Next »
Step	Action					
5	Review th	e information on the r	age and selec	t Next		
5	1.001000 01		age and belee			

The Re-Verification Application – Terms and Conditions page displays.

Re-Verification Application - Terms and Conditions	
* indicates a required field	Legend 🔻
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDER ADMINISTRATIVE PARTICIPATION AGRE 1. Parties to the Agreement This Agreement is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the the above identified provider, hereinafter referred to as the "Provider."	EMENT e "Department", and
2. Agreement Document The Agreement Documents shall consist of this Agreement, any addendum, and the Provider's application, incorporated herein by reference modifications shall be made to the terms of this Agreement unless through a written amendment executed by both parties. In the event of the terms of this Agreement and any of its addenda, the terms of this Agreement shall control.	a. No alterations or any conflict between
3. Governing Law and Venue This Agreement shall be governed by the laws of the State of North Carolina, exclusive of its conflicts of laws provisions. In the event of a l Agreement, venue shall be proper only in Wake County, North Carolina. This Agreement shall not be construed as waiving any immunity to including, without limitation, sovereign immunity, which may be available to the Department.	awsuit involving this suit or liability
The Provider agrees to operate and provide services in accordance with all federal and state laws, regulations and rules, and all policies, p , implementation undates, and bulleting published by the Department, its Divisions and/or its fiscal-agent in effect at the time the service is r	rovider manuals, sodeced, which are





ATTESTATION		
I certify that the response	es in this attestation and information contained in the documents submitted with the application/enrollment	
documents /Administrative Dart	ticination Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein	
documents/Administrative Part	depader Agreement are trace, accurate, complete, and carrent as of the date and attestation is signed. I have not nerven	
knowingly or willfully falsified,	concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.	
knowingly or willfully falsified,	concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.	
knowingly or willfully falsified,	concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.	7
knowingly or willfully falsified,	concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.	7

Step	Action
6	Read the Terms and Conditions page as you scroll down the page.
7	Select the Attestation checkbox and select Next.

The **Ownership Information** page displays only for Organization NPIs in which the Business Type equals Corporation, Non-Profit, Partnership, or Limited Liability Corporation (LLC).

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 - John , HAZEL (AUTHORIZEDINDIVIDUAL)	
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	
	†
W Previous Please be sure to required fields with value	complete all Next >>
Save	Draft Delete Draft

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





Ownership Information				
* indicates a required field				Legend 🔻
Do you have one or more Shareholde	rs/Partners with 5% or more owner	ship? Yes		
SHAREHOLDER/PARTNER INFORMATION				?
- INDIVIDUAL -	(AUTHORIZEDINDIVIDUAL)			
Last Name :	1000.00	First Name :	100.000	
Middle Name :		Suffix :		
SSN :	10000			
Gender :	(Received)			
Email :	IN COLUMN STREET, COMP.	Phone Number :	10.00740.01741	
☑ I attest that I have entered t	he full legal name of the individual,	and the individual does not have a mide	dle name.	
Address Line 1 : Address Line 2 :	10.01.0010.000.000			
City :	1010.0.0.0.001			
State :	101100-0011-01010-011-00001			
ZIP Code :	128801-18231			
Relationship to Another Disclosing Person :	None	Percent of Ownership/Control Interest :	100 %	
Begin Date :	11100170000	End Date :		
				9 Edit
Add Shareholder/Partner				• =
Please complete the required info	rmation for <i>each</i> shareholder/partne	r with 5% or more ownership.		
W This shareholder/partner is				
	•			
				10 *
« Previous			Please be sure to required fields with v	complete all alid content. Next >>

Step	Action
9	Select Edit to update the owner's information or to end-date the person if they are no longer an owner of the organization.
10	Select Next.

The Agents and Managing Employees page displays for all Individual and Organization NPIs.





Agents and Managing	g Em	oloyees		6	A A Help
indicates a required field	- '	-			Legend 💌
					?
RELATIONSHIP DISCLOSURE					-
As required by 42 CFR 1002 Funds Transfer (EFT) autho Failure to provide the requi	2.3, pro rized in red info	viders must disclose the followin dividual. rmation may result in a denial fo	g for each individual officer, managing em	ployee, director, board member, and	Electronic
Does the applicant have any	y agent(s) and/or managing employee(s)? Yes		2
Managing Relationships					1
Please add all managing re	elations	ips below.			
- MANAGING RELATIONS	HIP - U	HAZEL (AUTHORIZED I	NDIVIDUAL MANAGING CONTACT)		
Last N	lame :	1818.02	First Name :	NUMPE:	
Middle N	lame :		Suffix :		
	SSN:	1011108981			
E	Email :	101010320-010	Phone Number :		
Business Relation	nship :	Managing Employee	Relationship to Another Disclosing Person :	None	
✓ I attest that I have e	entered	the full legal name of the individ	ual, and the individual does not have a mi	ddle name.	
Address Li	ine 1 :				
Address Li	ine 2 :	and a second second			
	City :	0.0.000			
s	State :	BIRE CONTRACTOR			
ZIP	Code :	1001-008			
Begin	Date:	10/19/2017	End Date:		
					11 Edit
	-				
Step Action	_				
	14.4		n n Ennelsus sis infermenti	an to an al slate the same	

Otep	
11	Select Edit to update the Managing Employee's information or to end-date the person if they no longer hold that role within the organization.
	Note: All changes will need to be saved after information has been altered.

The **Re-verification Application – Accreditation** page displays for Individual providers only.





🚔 | A A | Help

Re-Verification Application - Accreditation

* indicates a required field				Legend	
Review board certifications listed be	low. Edit and add all of your board certification	ns.			
CERTIFICATIONS					?
Add Certification					
Select a certification type from the	drop down list and provide the certifying enti	ity and certification number.			
Certification Type:	Select One	•			
Certifying Entity:	Select One	T			
12 State:	NORTH CAROLIN V				
Certification #:					
Effective Date:	mm/dd/yyyy 🗾	Expiration Date:	mm/dd/yyyy		
				13 Add Clear :	÷
					+
((Previous				14 Next))
				Save Draft Delete	Draft

Step	Action
12	 Review, edit, and/or enter your board certifications information such as Drug Enforcement Agency (DEA) certifications. Certification Type Certifying Entity State – Select the state in which you are certified from the drop-down menu. Certification # Effective Date Expiration Date
13	Select Add.
14	Select Next.

The Provider Supplemental Information page displays for Individual providers only.





Provider Supplemental Information

						Lagond
						Legend
WORK HISTORY						
Enter your work history as a health more than six months, please uploa	professional for ad documentation	the past 5 years. W t clarifying the gap t	ork history prior upon application	to 5 years ago is not ne submission.	eeded. If there is a gap	in your employment
Add Work History						
* Company Name:				* Job Title:		
* Start Date:	mm/dd/yyyy			* End Date:	mm/dd/yyyy	
EDUCATION						
Enter your highest level of education	on completed.					
Add Education History						
* School Name:				* Degree:		
* Start Date:	mm/dd/yyyy			* Graduate Date:	mm/dd/yyyy	
CURRENT MALPRACTICE INSURANCE COV	ERAGE					
Medical providers should carry prof your profession, including allegation you at any time after you have see	essional liability on ns of malpractice n a patient.	coverage, often calle . Liability insurance	ed malpractice in offers essential f	surance. This insurance inancial protection beca	covers your exposure use a malpractice suit	to liability arising from can be brought again
Enter your current malpractice insu	n a patient. Irance coverage.	Upon submission of	the application,	upload a copy of the ins	surance face sheet fron	n the malpractice carr
a copy of the rederal tortletter of a	n attestation from	i the practitioner of	rederal tort cove	raye.		
Do you have malpractice insurance Over ONO	ce or are you cov	ered under a federa	I tort?			
O Tes O NO						
						18
Previous					Please be required fields	sure to complete all s with valid content.
						Save Draft Dol
						Sare brait bei
CURRENT MALPRACTICE INSURANCE COV	ERAGE					
Medical providers should carry prof	essional liability ns of malpractice on a patient.	coverage, often call A. Liability insurance	ed malpractice in offers essential	nsurance. This insuranc financial protection be	e covers your exposur cause a malpractice sui	e to liability arising fr it can be brought aga
you at any time after you have see						
you at any time after you have see Enter your current malpractice insu or a copy of the federal tortletter o	rance coverage. r an attestation f	Upon submission of rom the practitioner	f the application, r of federal tort o	upload a copy of the in coverage.	nsurance face sheet fro	om the malpractice ca
you at any time after you have see Enter your current malpractice insu or a copy of the federal tortletter o * Do you have malpractice insurand	irance coverage. r an attestation f ce or are you cov	Upon submission or rom the practitioner rered under a federa	f the application, r of federal tort o al tort?	upload a copy of the in coverage.	nsurance face sheet fro	om the malpractice ca
you at any time after you have see Enter your current malpractice insu or a copy of the federal tortletter o * Do you have malpractice insurant • Yes O No	irance coverage. r an attestation f ce or are you cov	Upon submission of rom the practitioned rered under a federa	f the application, r of federal tort o al tort?	upload a copy of the in coverage.	nsurance face sheet fro	om the malpractice ca
you at any time after you have see Enter your current malpractice insu or a copy of the federal tortletter o * Do you have malpractice insurance • Yes O No Add Malpractice * Malpractice type:	r an attestation f ce or are you cov	Upon submission o rom the practitione rered under a federa	f the application, r of federal tort of al tort?	upload a copy of the in overage.	nsurance face sheet fro	om the malpractice ca
you at any time after you have see Enter your current malpractice insu or a copy of the federal tortletter o * Do you have malpractice insurant • Yes O No Add Malpractice * Malpractice type:	r an attestation i ce or are you cov Select One	Upon submission o from the practitione rered under a federa	f the application, r of federal tort of al tort?	upload a copy of the in overage.	mm/dd/uccor	om the malpractice ca
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Step	Action
15	 In the Work History section of the Provider Supplemental Information page, enter your work history as a health professional: Company Name – Employer name Job Title – Position/job title Start Date – Start date of the job title at this company End Date – End date of the job. If you still hold this job title at this company, enter 12/31/9999.
16	 In the Education section, enter your Education information: School Name – School or institution name Degree – Highest degree Start Date – Date started at the school or institution Graduation Date – Date graduated from the school with this degree
17	 In the Current Malpractice Insurance Coverage section, enter/select the following: Do you have malpractice insurance or are you covered under a federal tort? – Select Yes if you have malpractice insurance or are covered under a federal tort. Malpractice Type – Select the type of malpractice coverage. Insurance Agency Name – Enter the name of the malpractice insurance agency. Amount – Enter the amount of malpractice coverage. Effective Date – Effective date of the coverage Expiration Date – Expiration date of the coverage
18	Select Next.

The Exclusion Sanction Information page displays.



Clusic	on Sanction Information	🚔 I A A I
indicates a r	required field	Legend
Exclusion	SANCTION INFORMATION	
The que 1002.3.	stions below must be answered for the enrolling provider, its owners, and agents' in accordance with 42 CFR 455.100; 101; 104; 106	and 42 CFR
* [†] An gen boa	agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This may include mar eral managers, business managers, office managers, administrators; Electronic Funds Transfer (EFT) authorized individuals, individua rd members, etc.	naging employees I officers, director
• All a	applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.	
For each clearly in	question answered yes, you must submit a complete copy of the applicable criminal complaint, Consent Order, documentation, and/ ndicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this app	or final dispositior lication.
 A. Has elony, or Yes 	s the applicant, managing employees, owners, or agents ever been convicted of a felony, had adjudication withheld on a felony, pled entered into a pre-trial agreement for a felony? ONo	no contest to a
Please #	add up to 5 Infraction/Conviction Dates.	
= INF	RACTION/CONVICTION DATES	
0 00/0	Infraction/Conviction Date	
	/d/vyvy Z	
-		Add Ch
		Add Ci
ny other ertifying rovided, O Yes	State, or has your license to practice ever bear restricted, reduced, or revoked in this or any other state to been previously found by, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the qu or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?	a licensing, ality of services
C. Has om Med r profess rivate he uspende ealth ins O Yes	a the applicant, managing employees, owners, or agent sever been denied enrollment, been suspended, excluded, terminated, or involicare, Medicaid, or any other government or private health care or health insurance program in any state; or been employed by a cor sional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare , Medicaid, or any ot ealth care or health care or involuntarily withdrawn from Medicare, Medicaid, CHIP, or any other government or private health care or surance program in any state?	oluntarily withdra poration, busines her government lier that has beer r health care or
D. Has	s the applicant, managing employees, owners, or agent sever had suspended payments from Medicare or Medicaid in any state; or be on, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state; or ever been dire with a provider or supplier that ever had suspended payments from Medicare, Medicaid or CHIP in any state?	een employed by actly or indirectly
E. Has	s the applicant, managing employees, owners, or agents ever had civil monetary penalties levied by Medicare, Medicaid, or other Stat m, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?	e or Federal Ager
F. Doo ffiliated	INO es the applicant, managing employees, owners, or agents owe money to Medicare or Medicaid that has not been paid; or ever been di with a provider or supplier that has uncollected debt owed to Medicare, Medicaid, or CHIP? No	irectly or indirect
K G. Has buse of ⊖Yes	s the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense related t a patient in connection with the delivery of any health care goods or services? Image No	to the neglect or
H. Hat hanufact	s the applicant, managing employees, owners, or agents ever been convicted under federal or state law of a criminal offense relating ure, distribution, prescription, or dispensing of a controlled substance? No	to the unlawful
K I. Has duciary I O Yes	the applicant, managing employees, owners, or agents ever been convicted of any criminal offense relating to fraud, theft, embezzle responsibility, or other financial misconduct?	ment, breach of
	the applicant, managing employees, owners, or agent sever been found to have violated federal or state laws, rules, or regulations g	overning North
J. Has arolina's anctione evoked?	Medicaid program of any other state's Medicaid program of any publicly funded federal of state health care of health insurance program d accordingly; or ever been directly or indirectly affiliated with a provider or supplier that had its Medicare, Medicaid, or CHIP billing p	ram and been privileges denied (
J. Has arolina's anctione evoked? O Yes	Medicaid program or any other state's Medicaid program or any publicly funded federal or state health care or health insurance prog d accordingly; or ever been directly or indirectly affiliated with a provider or supplier that had its Medicare, Medicaid, or CHIP billing p No	ram and been privileges denied o





Step	Action
19	Answer each question by selecting the Yes or No radio button.
	Note:
	 These questions pertain to all providers, owners, and managing employees listed in the provider record.
	 When Yes is selected for a question, the Infraction/Conviction Dates section displays. Select the appropriate date of the infraction or conviction. Select the Add button to add the information to the application.
	 At the end of this application, you must electronically upload 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 this application.
20	Scroll down the page and select Next .
	Note: You may also elect to:
	Save Draft: The draft will appear in the Saved Applications section of the Status and
	Management page. Refer to <u>Appendix A</u> of this document to learn more.
	• Delete Draft: Will delete the application, and the Net line will remain in the Re-verification section of the Status and Management page

The **Re-Verification Application – Federal Requirements** page displays for providers whose taxonomy classification is categorized as moderate or high risk.

NC TO A CIVICI	🔒 Welcome,
CILIRACIS	I NCTracks Help
Provider Portal	Eligibility Prior Approval Claims Referral Code Search <u>Enrollment</u> Administration Payment Trading Partner Consent Forms
Home Provider Enrollment Online Prov	rider Enrollment Ap
Provider Enrollment	Re-Verification Application - Federal Requirements
NOTE: Data is not saved unless the 'Next' button is activated.	* indicates a required field
Contact CSRA Call center	- Federal Site Visit
	Based upon the health plans and taxonomy codes you have applied, your application requires you to complete a Federal Site Visit before your application will be approved.
	If you completed a Federal Site Visit with another state Medicaid program, you must be able to provide proof of completion. If you are unable to provide proof, select NO.
	* Have you completed the Federal site visit for this site to another state or Medicare? 21
	* Other State: V
	FEDERAL FEE
	Section 6401(a) of the ACA requires the State Medicaid Agency to impose the fee. Based upon the health plans and taxonomy codes you have applied, your application requires you to pay the Federal Fee.
	If you paid the Federal Fee to another state Medicaid program, you must be able to provide proof of payment. If you are unable to provide proof, select NO.
	Have you paid the Federal Fee for this site to another state or Medicare?
	* Other State:
	*
	(1 Previous 23 Next.))
	Save Draft Delete Draft





Step	Action
21	 Answer the question 'Have you completed the Federal site visit for this site to another state or Medicare?'. Answer No – If you have not had a site visit or are unable to provide proof of completion. Answer Medicare – If you have had a site visit for Medicare certification purposes. Answer Other State – If you have met this requirement for another state. If Other State is selected, you will need to select the state from the drop-down menu.
22	 Answer the question 'Have you paid the Federal Fee for this site to another state or Medicare?'. Answer No – If you have not paid the fee or are unable to provide proof of payment. Answer Medicare – If you have paid the fee for Medicare certification purposes. Answer Other State – If you have met this requirement for another state. If Other State is selected, you will need to select the state from the drop-down menu.
23	Select Next.

The **Review Application** page displays.

Review Application	
* indicates a required field	Legend 🔻
EMAIL CONFIRMATION The below email address is the email for the Office Administrator for this provider. During the approval process, communication will be	sent to this email
 address. If the email below is incorrect, you will need to complete a Manage Change Request (MCR) application to update the email address. To MCR, delete this draft and navigate to the <u>Status and Management Page</u> to begin the MCR. 	o complete the
Contact Email: 24	
REVIEW APPLICATION	
To review your application in Adobe PDF format, click ' Review Application ' below. If you have successfully completed all required informat provider enrollment application and are satisfied the information is complete and accurate, you may proceed to the Attachments/Submit El Application page by clicking 'Next'.	tion for your ectronic
25 Re	eview Application 🔎
((Previous	26 Next »
2	ave Draft Delete Draft

Step	Action
24	Verify the contact e-mail address listed on the page.
	Note: This e-mail address can be updated on the Basic Information page.
25	Select the Review Application button to review the application in Adobe PDF format.
	The application is a PDF document presenting all the information to which the provider attested during the Re-verification process. You will notice that the application does not provide the Date Submitted. This will not populate until the application has been submitted.
26	Once you have reviewed the application and are satisfied the information is complete and accurate, select Next to proceed to the Sign and Submit Electronic Application page.

The Re-Verification Application – Sign and Submit Electronic Application page displays.





				Legend
or any reason you navigate awa	y from this page without clicking `Su	bmit Now', you will be required to re-e	enter the information.	
ECTRONIC SIGNATURE CONFIRMATIO	DN			
testation: I have read and agro- cuments submitted with the app te this electronic document is su ministrative, civil, or criminal lia	eed to the terms and conditions of pa blication/enrollment documents/Admi Ibmitted. I do hereby attest that any bility.	rticipation. By submitting this form, I nistrative Participation Agreement are falsification, omission, or concealmen	confirm the information contain true, accurate, complete, and o t of material fact may subject m	ed in the current as of the ne to
* Login ID (NCID):		• Password:		
	Forgot Login ID	•	Forgot Password	
If this is your first Provider En complete submission. If the e Basic Information page to sto If there is a PIN already assoc and Password and clicking the	rollment submission, your Electronic mail is incorrect, you may now navig re your change.) iated with this NCID, please use it no 'Forgot PIN' link. The PIN will be ser	Signature PIN has now been sent to E ate back to the Basic Information page ow. If you have forgotten your PIN, yo at to your email address.	CRIDER@CSC.COM. Please re a to update it. (Remember to cli u may reset it by entering you l	trieve it now to ck Next on the Login ID (NCID)
28 * PIN:	Forgot PIN			
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Step	Action
27	Enter your Login ID and Password.
28	You will provide your electronic signature by entering your PIN .
29	Select Submit Now . Note : If you elect to Submit Later , you may risk termination. If the Re-verification program suspends or terminates a provider for not completing Re-verification and the provider has a draft MCR or Re-verification application (in process, not submitted), the program will mark the application as 'old'. This means the provider will still see the application in the Saved Applications section of the Status and Management page, but will receive an error message when he or she tries to resume the saved application.





The Final Steps page displays.

ONLINE SUBMISSION COMPLETE Thank you for submitting the online portion of your application. Please save/print the following documents for your records Online Application Courser.Sheet • Review Agreement Now that you have submitted your online application, you will not be able to retrieve the application or reprint application documents. APPLICATION FEE REQUIRED Thank you for applying to Medicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC Application Fee is required. Please click the Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now' button. Proceeding the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application you submitted requires fingerprinting. After Your application indicates that you are enrolling as: • Privisticin Assistrant's & ADVANCED PRACTICE NURSING PROV	ndicates a required field	Legend	
Thank you for submitting the online portion of your application. Please save/print the following documents for your records	ONLINE SUBMISSION COMPLETE		[
Evview Agreement Now that you have submitted your online application, you will not be able to retrieve the application or reprint application documents. APPLICATION FEE REQUIRED Thank you for applying to Medicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC Application Fee is required. Please click the 'Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application you submitted requires fingerprinting. After your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions for completing the fingerprinting process. See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail. No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	Thank you for submitting the online portion of your application. Please save/print the following documents for your records • <u>Online Application</u> • <u>Cover Sheet</u>		
APPLICATION FEE REQUIRED Thank you for applying to Medicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC Application Fee is required. Please click the Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application you submitted requires fingerprinting. After your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions for completing the fingerprinting process. See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail. No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	<u>Review Agreement</u> Now that you have submitted your online application, you will not be able to retrieve the application or reprint application documents.		
Thank you for applying to Medicaid and/or NCHC (Children). In order to complete your application, a \$100.00 NC Application Fee is required. Please click the Pay Now' button. You will be directed to Paypoint to make the payment. Pay Now FINCERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application you submitted requires fingerprinting. After your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions for completing the fingerprinting process. See Fingerprinting Information Page for more information. REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail. No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	APPLICATION FEE REQUIRED		
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REQUIRED ATTACHMENTS Your application indicates that you are enrolling as: • PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail. • No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	FINGERPRINTING REQUIRED In compliance with the federal regulatory requirements in 42 CFR 455.450(c) 455.101 and 455.434, the application you submitted requires your application has been received and reviewed by CSRA, the Office Administrator will be contacted with instructions for completing the fin See <u>Fingerprinting Information Page</u> for more information.	fingerprinting. Al gerprinting proce	fter ess.
Your application indicates that you are enrolling as: • PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mail. • No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	REQUIRED ATTACHMENTS		
No Required Attachments for the Taxonomy ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	Your application indicates that you are enrolling as: • PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS, Clinical Nurse Specialist, Psychiatric/Mental Health The following documents are required with your Provider Enrollment Application. They can be submitted electronically and/or by regular mat	ail.	
ELECTRONIC ATTACHMENTS If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	No Required Attachments for the Taxonomy		
If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also submit electronic	ELECTRONIC ATTACHMENTS		
attachments on the Status Management Page. 32 Upload Document	If you need to submit electronic attachments, you may do so at this time by clicking the Upload Documents button below. You can also sub- attachments on the Status Management Page.	nit electronic	nent

Step	Action
30	 As appropriate, open and save documents accessible through hyperlinks on the Final Steps page. Online Application: This is the same document that you reviewed during the application process. In this instance, the document will appear with a submitted date.
	Note: This link will be inaccessible once you move beyond this page.
31	When Fingerprinting is required, the system advises that the OA will be contacted with more information on completing the process.





Step	Action
32	 Select Upload Documents to navigate to the Upload Documents page to upload supporting documents. Documents required include the following: Supporting documents if the provider answered Yes to any of the questions on the Exclusion Sanction Information page. Supporting documents if the provider completed the Federal Site Visit or paid the Federal Fee to another state. Notification and Electronic Fingerprint Submission Release of Information Form if the application required fingerprinting and either the Individual provider or one of the owners has completed the fingerprinting process with NCTracks within the past 6 months.
33	Select the Provider Enrollment Status and Management Home hyperlink to return to the Status and Management page.

The Status and Management page displays.

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CALL IRACIO						I <u>NCTracks H</u>
Dravidar Dartal	Eligibility Prior A	nnroval Claims Referral C	ode Search Enrollment A	dministration Payment Tra	ling Partner C	incent Forms
Nome I Status and Management	Lingibility					
· Itome · Status and Hamagement						
Contact Information	Status and M	anagement				🚔 A A <u>He</u> l
If you have any questions regarding completion of Provider Enrollment, please contact CSRA Call Center.	* indicates a required fi	eld				Legend
Phone: 800-688-6696	Welcome to Pro	vider Enrollment Status	and Management			
Fax: 855-710-1965	Please choose from the options below to manage your enrollment status.					
Lindi. <u>Winadisprovider prictiadis.com</u>	- SUBMITTED APPL	CATIONS				?
Ouick Links	Below is the status of applications you have submitted.					
Online Application	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					
Advanced Medical Home Tier	If status of the	application is in Payment Per	nding. Returned, or In Rev	iew, you can upload suppor	ting documents	tion by clicking the Upload Documents
Attestation	n sadas or de application is in Payment Pending, Returned, or in Review, you can upload supporting documentation by clicking the opload bocuments hyperfink.					
Provider Enrollment Home	- RECORD RES	ULTS				
PE Terms and Conditions	NPI/Atypical ID	Name	DBA Name	Application Type	Submit Date	Status
Applications	00000010			RE-VERIFICATION	07/17/2018	Pay Now , Upload Documents - Payment Pending
				MANAGE CHANGE REQUEST	10/09/2017	Manage Change Request Complete 34

Step	Action
34	 Re-verification applications require online fee payment: A \$100 NC Application Fee is required from providers if active in Medicaid and/or NCHC. Federal Fee for providers whose taxonomy classification is categorized as moderate or high risk and who have not completed the requirements within the past 5 years. Select Pay Now to pay the total amount due.

You will follow the process for payment as guided by the system. Once the payment process is completed, the **Payment Confirmation** page displays. Processing time may vary depending on whether additional information is required. You will receive an e-mail or a phone call if additional information is needed.

Note: The OA will receive an e-mail with a copy of the confirmation.





Paym	ent Confirmation	
k indicat	tes a required field	Legend
ONL	INE PAYMENT SUBMISSION COMPLETE	
Belo Payr Cont	w is your payment summary and confirmation; please pr ments are posted and the payment status will be update tact the CSRA Call Center at if you have a	int the page for your records. In within 2 business days of being received. In questions about this payment.
PAYA	NENT CONFIRMATION DETAILS	?
Con	firmation Number:	
	NPI/Atypical ID: Provider Name:	
1	Payment Amount:	
		*
	Return to	Provider Enrollment Status and Management Hon
Step	Action	
35	Select the Provider Enrollment Status and Ma	nagement Home hyperlink to exit the page

Select the **Provider Enrollment Status and Management Home** hyperlink to exit the page and complete the Re-verification process.





Appendix A. Sections of the Status and Management Page

SUBMITTED APPLICATIONS SECTION

The **Submitted Applications** section displays the status of all submitted applications. Here, the provider is able to see the status specific to their submitted application. Some examples are Withdrawn, In Review, Abandoned, and Approved.

	Approvai Giaims	Reterrai	Code Search	Enrosiment	Administration Trac	ang narmer Pr	ayment	Consent Forms	iraining	
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USMITTED APP	LICATIONS									ſ
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lelow is the s	tatus of applicatio	ns you hav	ve submitted.							
Below is the s f status is Par payment. If st	tatus of applicatio yment Pending, w atus is Pay Now, y	ns you hav e have rec your NC A	ve submitted. eived initial c	onfirmation	from Paypoint that y	our payment v 1: click Pay No	was cor	ifirmed; it may i	take up to	48 hours to verify the
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SAVED APPLICATIONS SECTION

The **Saved Applications** section displays those applications that have been initiated but have not yet been submitted. When you are ready to continue working with the application, you must select the NPI and select **Resume**. You may also delete the application by selecting **Delete Draft**.

Pleas	e remember that your nplete application will	application must be submitted be deleted.	to the State within 9	0 days of the da	ite it was created. If no	t completed within 90 da	ys, the		
- R	- RECORD RESULTS								
Select	NPI/Atypical ID	Name	DBA Name	ZIP Code	Application Type	Application Create Date	Last Saved		
0				27502- 1216	Manage Change Request	07/21/2015	07/21/2015		
0				27502- 1216	Manage Change Request	07/01/2015	10/01/2019		
0				48433- 9451	Manage Change Request	07/27/2015	07/27/2019		
0				27502- 1216	Manage Change Request	07/21/2015	07/21/2015		
0				27295- 6848	Manage Change Request	10/12/2015	10/12/2015		
0				27607- 3073	Manage Change Request	07/23/2015	07/27/2015		





MANAGE CHANGE REQUEST SECTION

The **Manage Change Request** section allows the provider to edit or update information that may be missing from their record. You would initiate an MCR by selecting the NPI line and selecting **Update**.

NCTrac The fol	are a benavioral nealth pro ks Manage Change Reques lowing provider accounts a	vider contracted with a Local Managemen st application, please ensure your LME/MC associated with your NCID are active. Plea	o has the same updated data on file se select the account with which yo	(LME/MCO) and you o ou would like to submit	ipdate your dat t a Manage Cha	inge
- REC	t, then click Update.					
Select	NPI/Atypical 1D	Name	DBA Name	ZIP Code	Begin Date	Statu
0	A REAL PROPERTY.	and a second of the second sec		27617-4833	05/01/2006	Active
0				27217-2968	05/14/1993	Active
0				28054-1749	02/01/1998	Active
0				27560-6224	02/01/1989	Active
0				27615-4731	01/16/2014	Active
0				27617-4754	07/08/2013	Active
0				27606-1834	08/02/2007	Active
0				27615-2968	08/02/2007	Active
0				27616-2944	10/16/1979	Active
0				27560-8489	09/01/1999	Active
						Upda

RE-VERIFICATION SECTION

The **Re-verification** section displays all NPIs that are due for Re-verification under a particular provider or OA. This is where we will complete the process for Re-verifying a provider's record. You would initiate the Re-verification process by selecting the NPI line and selecting **Re-Verify**.

