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 ID _____. It is important that you submit the Re-verification Application on or before _____ 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:

1. **Login to the NCTracks Secure Provider Portal (http//www.nctracksnc.gov)**
2. **Navigate to the Status and Management Page**
3. **Your NPI/Atypical ID 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:

1. **Login to the NCTracks Secure Provider Portal (http//www.nctracksnc.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**

MORE INFORMATION

- **Please visit the NCTracks website (http//www.nctracksnc.gov) for more information about 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 provider information, 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

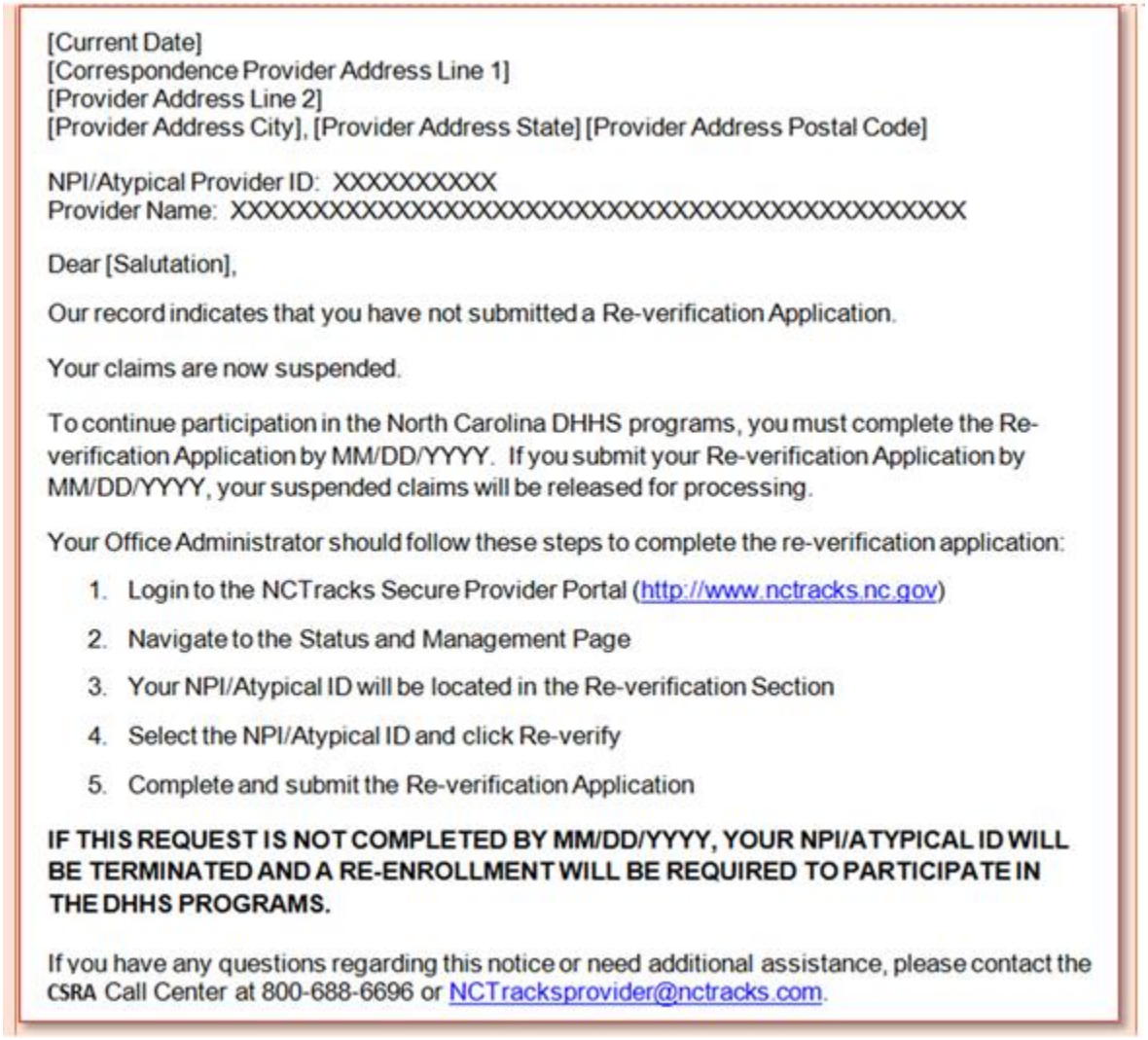
SUSPENSION LETTER

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.



[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: XXXXXXXXXX
Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Dear [Salutation],

Our record indicates that you have not submitted a Re-verification Application.

Your claims are now suspended.

To continue participation in the North Carolina DHHS programs, you must complete the Re-verification Application by MM/DD/YYYY. If you submit your Re-verification Application by MM/DD/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 THIS REQUEST IS NOT COMPLETED BY MM/DD/YYYY, YOUR NPI/ATYPICAL ID WILL BE TERMINATED AND A RE-ENROLLMENT WILL BE REQUIRED TO PARTICIPATE IN THE DHHS PROGRAMS.

If you have any questions regarding this notice or need additional assistance, please contact the CSRA 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

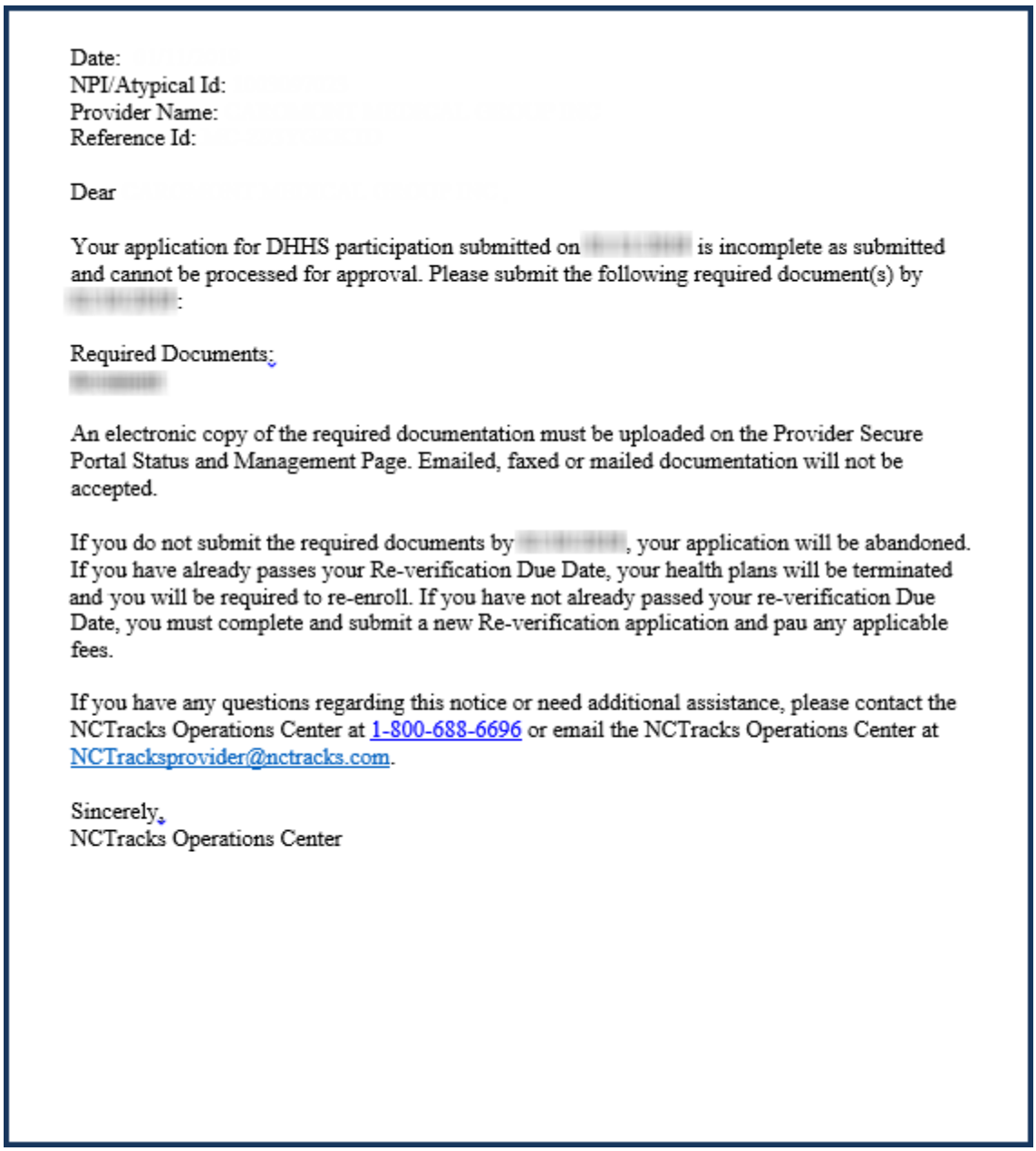
Dear Provider Name,

Your participation in the following DHHS health plan has been terminated:

Health Plan: [Health Plan Identifier]
Health Plan: [Health Plan Identifier]
Health Plan: [Health Plan Identifier]
Health Plan: [Health Plan Identifier]
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 1-800-688-6696 or email the NCTracks Operations Center at NCTracksprovider@nctracks.com.

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

Date: MM/DD/YYYY
NPI/Atypical ID: XXXXXXXXXX
Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Reference ID: XXXXXXXXXXXXX

Dear XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX,

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.

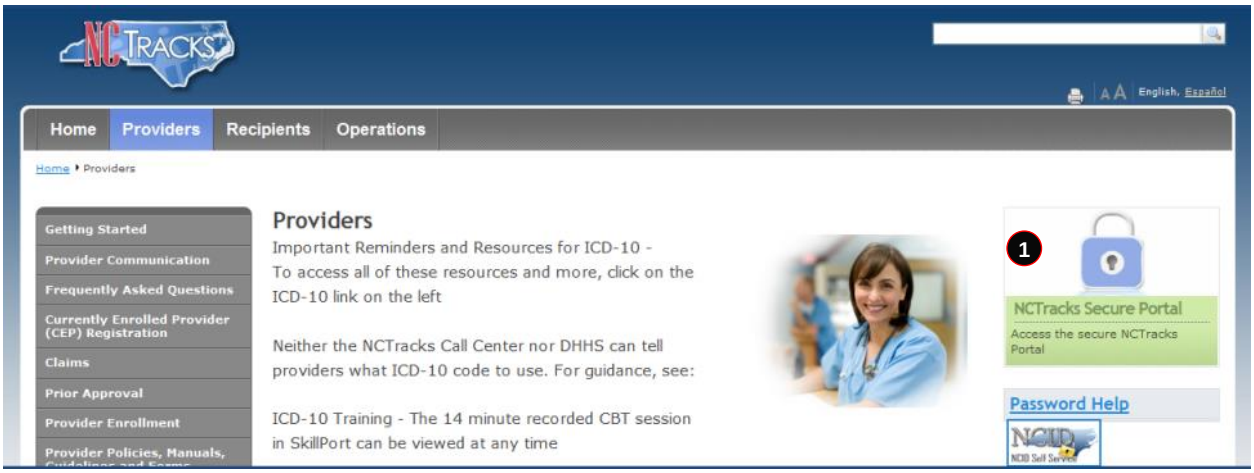
For Enrollment, Re-enrollment, and Manage Change Request Applications, print this paragraph: You must complete and submit a new application and pay any applicable fees.

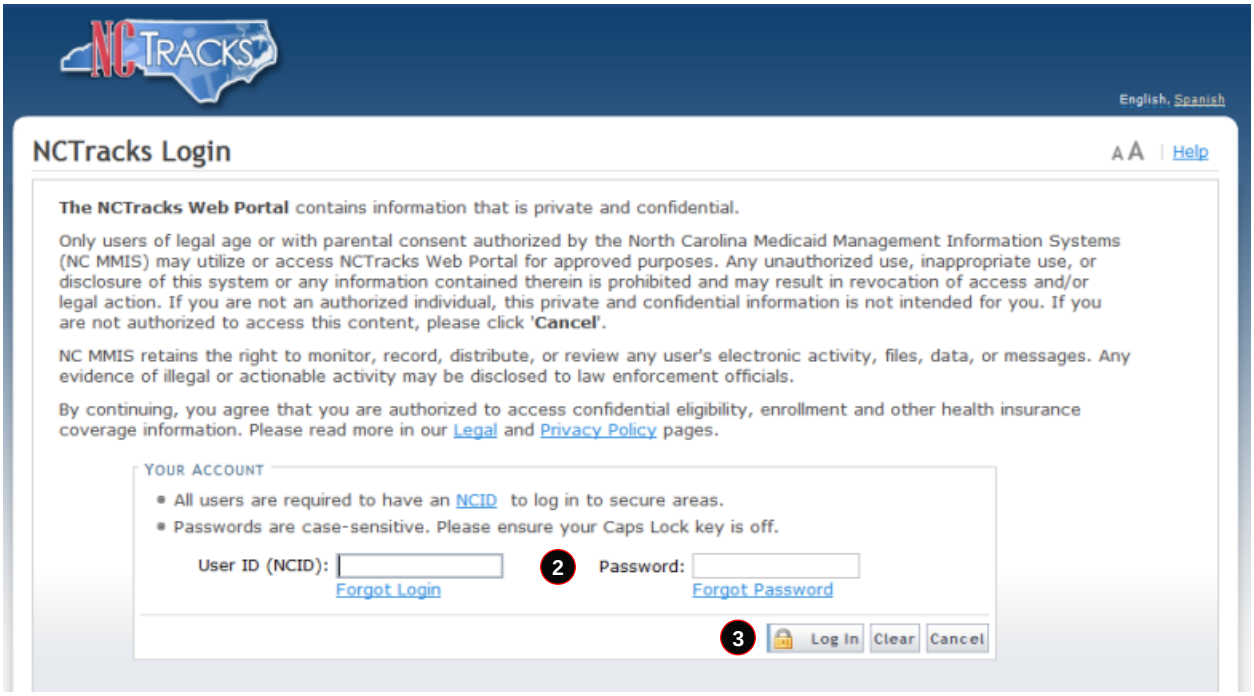
If you have any questions regarding this notice or need additional assistance, please contact the NCTracks Operations Center 800-688-6696 or email the NCTracks Operations Center at NCTracksprovider@nctracks.com.

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.

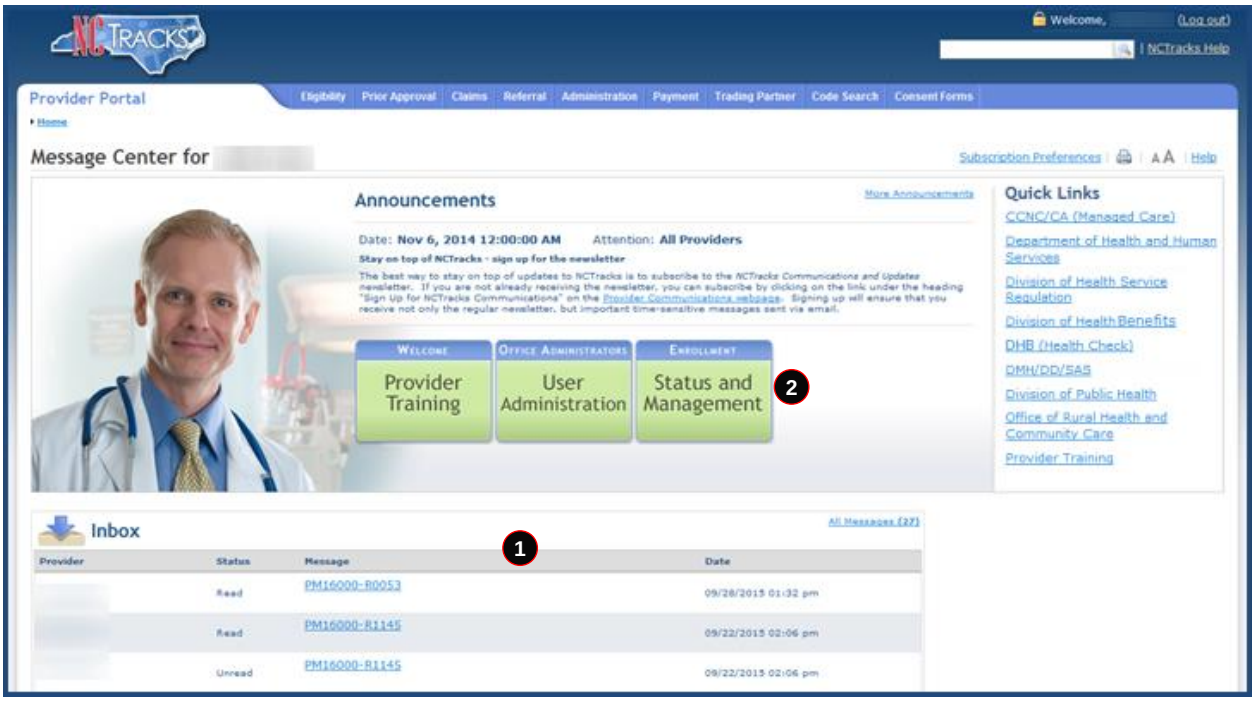
The NCTracks **Provider Portal Home** page displays.

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.



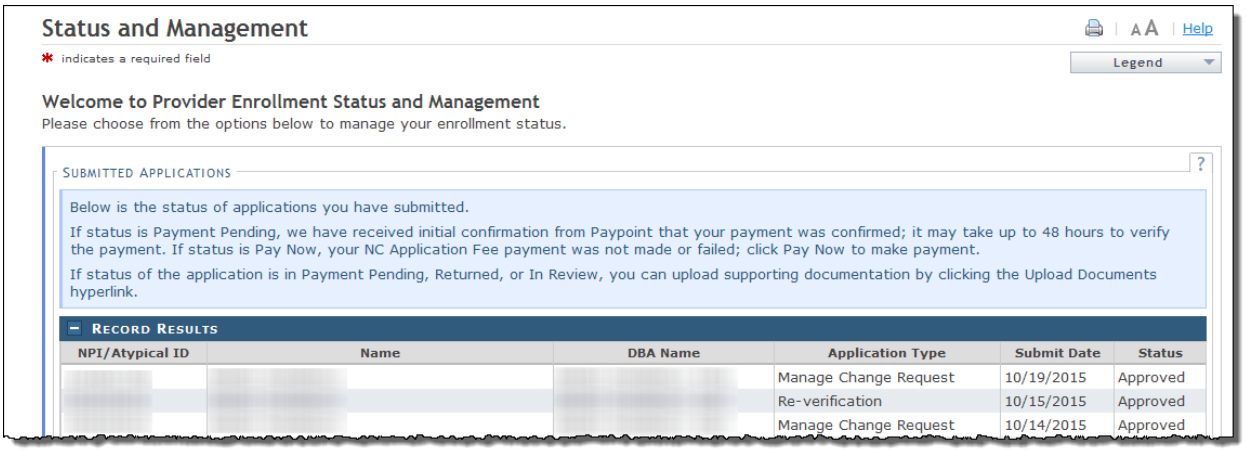
Step	Action
1	A Re-verification Letter is sent to the provider's NCTracks Inbox, alerting the provider that they need to complete the Re-verification application.
2	Select **Status and Management**.

The **Status and Management** page displays.

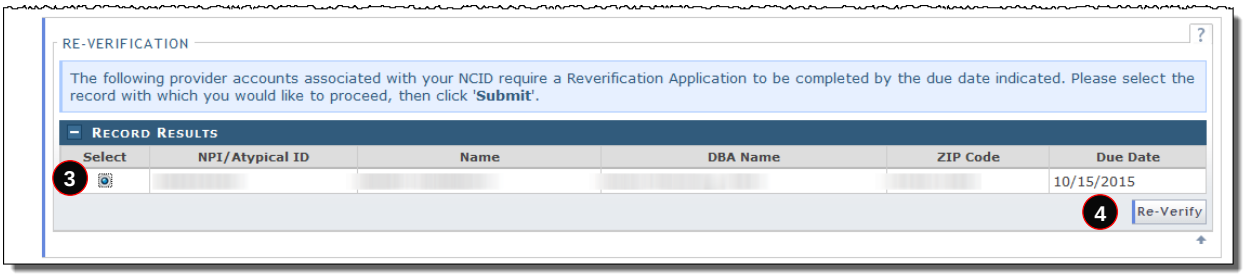
Status and Management Page

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 Appendix A, Sections of the Status and Management Page.



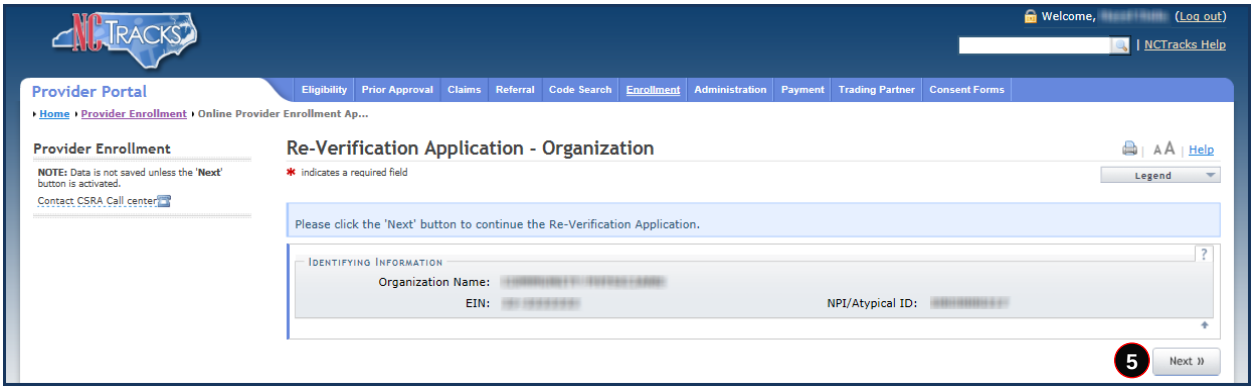
The **Re-verification** section displays all National Provider Identifiers (NPIs) that are due for Re-verification under that particular OA.

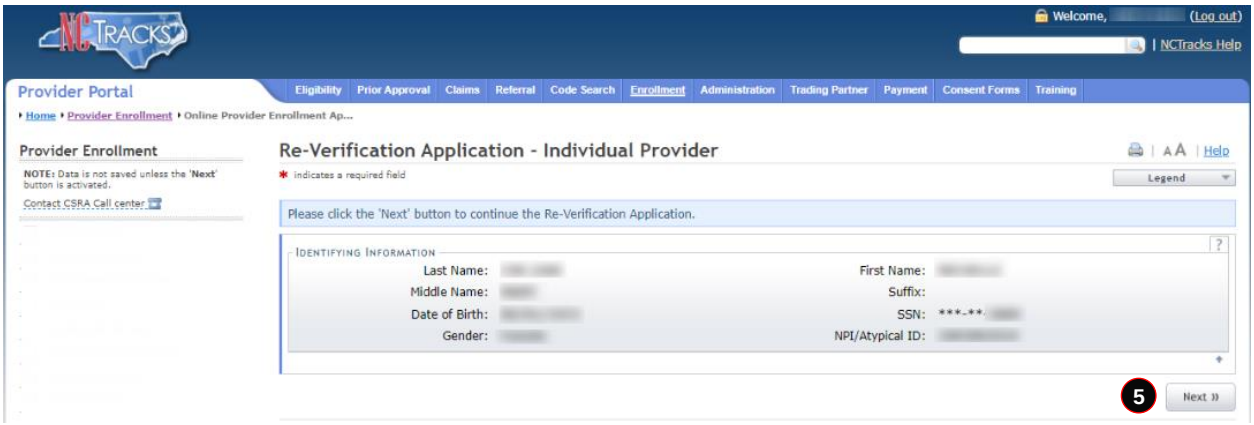


Step	Action
3	Select the line with the desired NPI.
4	Select **Re-Verify**.

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

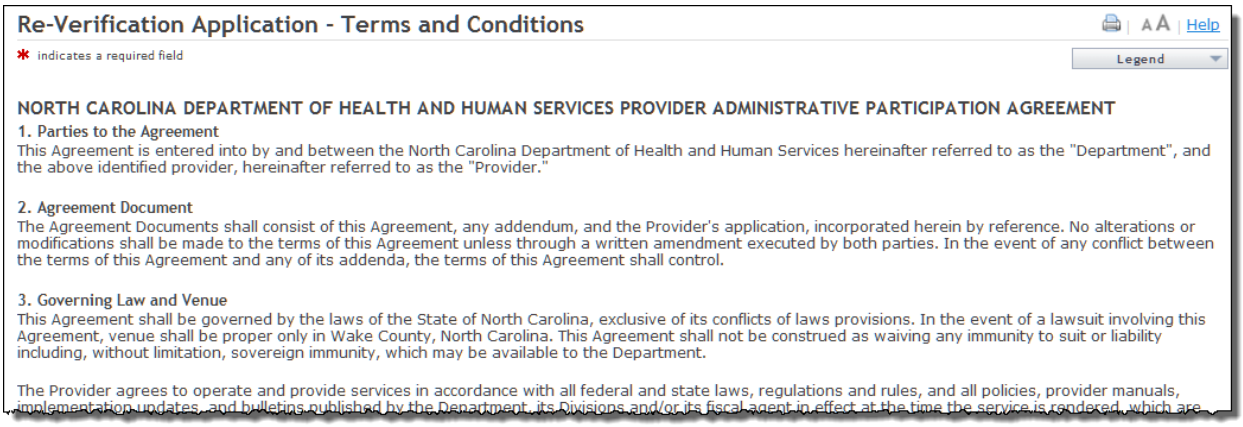
This page presents specific information about you as an Organization or Individual provider. This information must match what is reported on your income tax return.

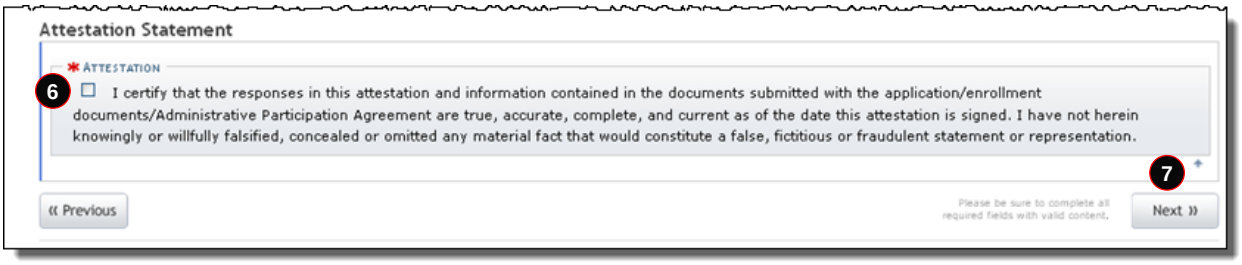




Step	Action
5	Review the information on the page and select **Next**.

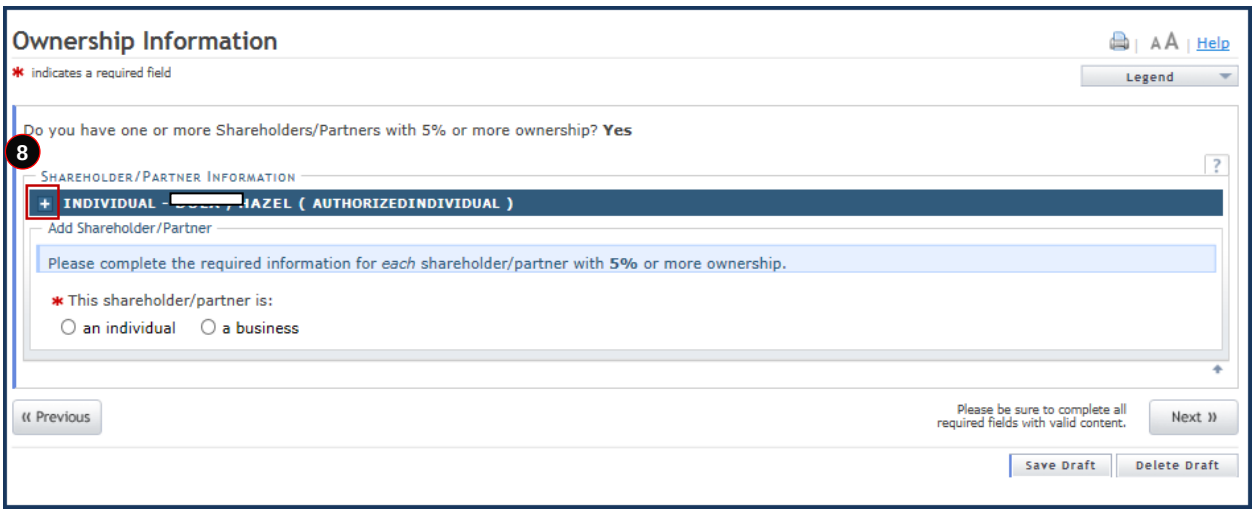
The **Re-Verification Application – Terms and Conditions** page displays.



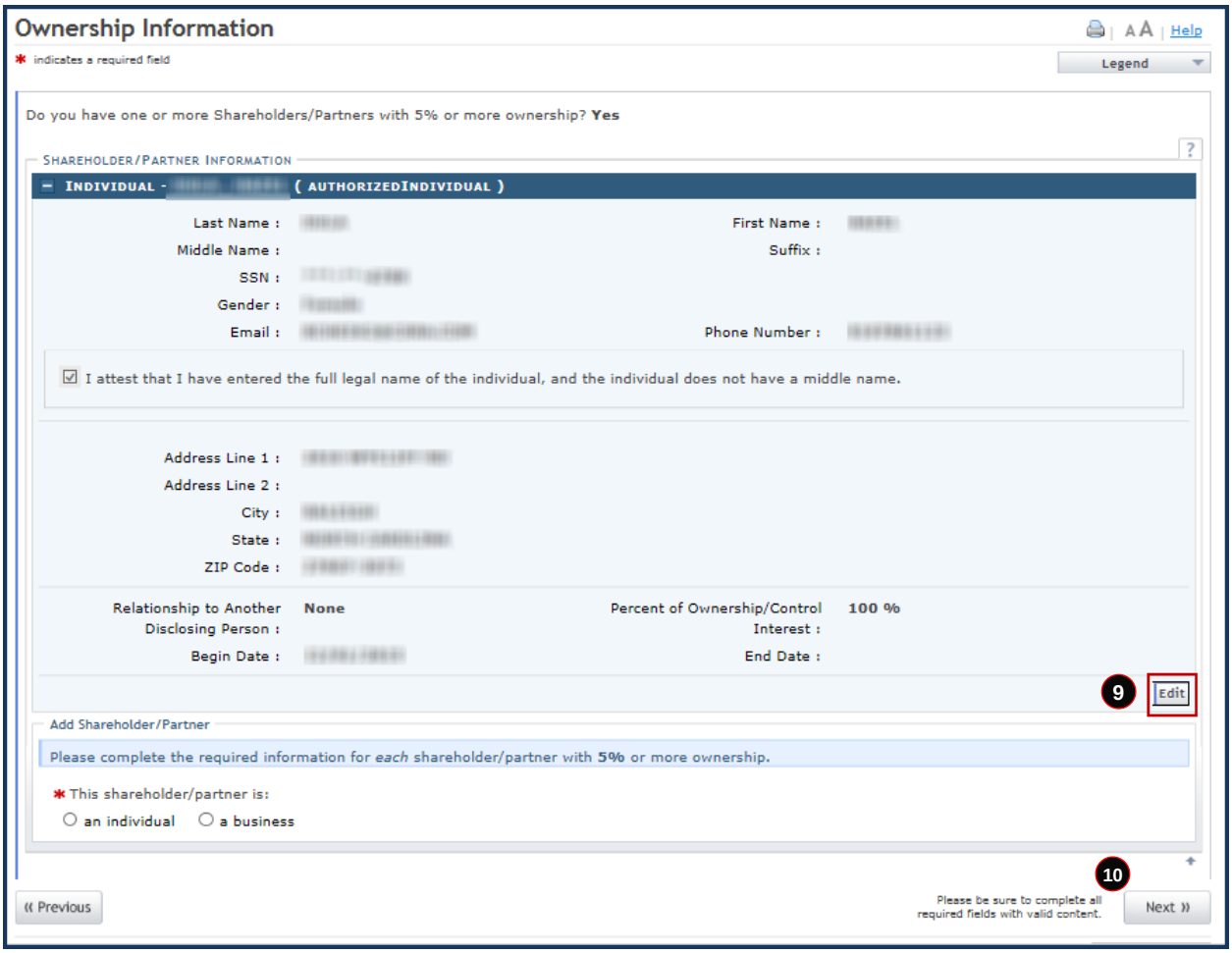


Step	Action
6	Read the **Terms and Conditions** page as you scroll down the page.
7	Select the **Attestation** checkbox and select **Next**.

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

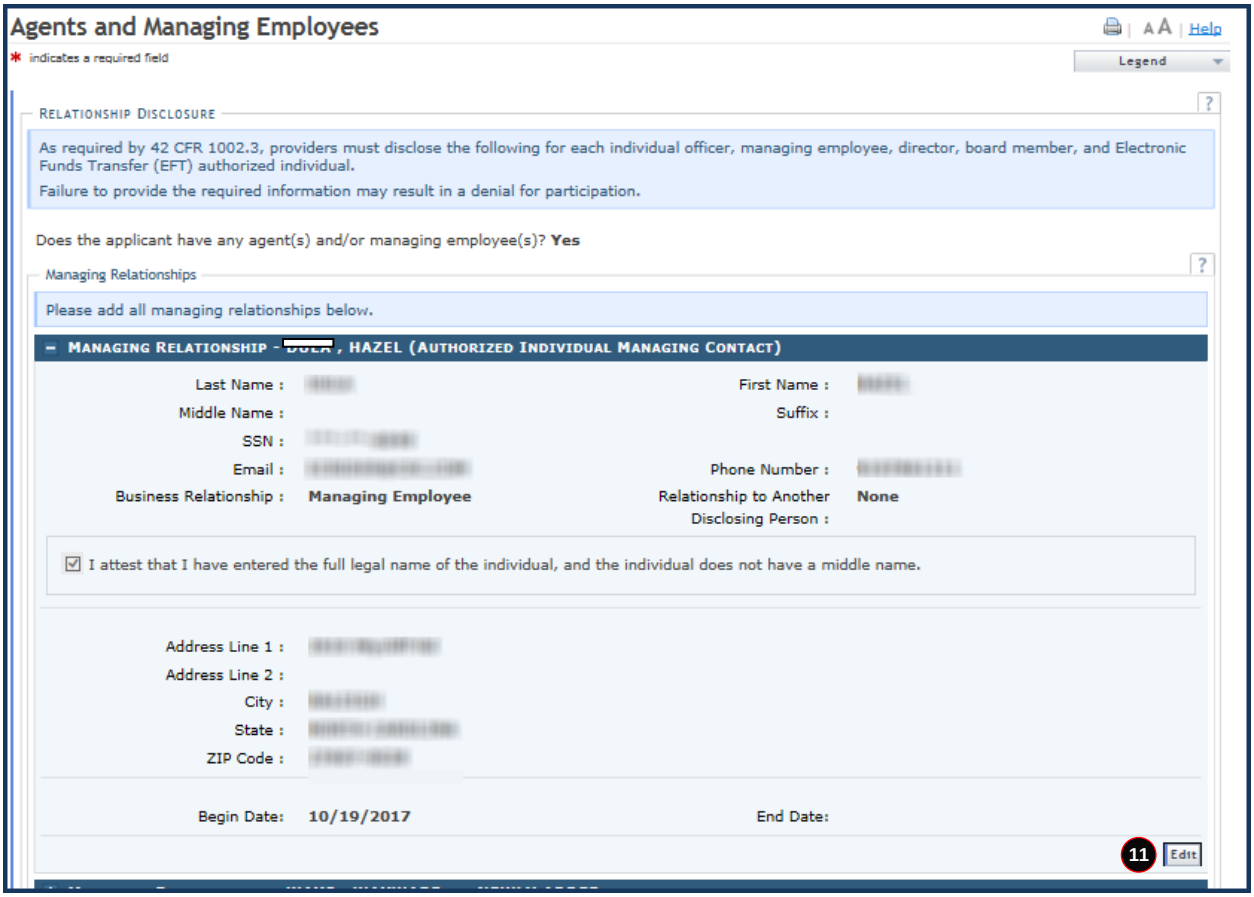


Step	Action
8	Select the **plus (+) sign** next to the individual or business that needs to be reviewed and possibly edited. The section will expand.



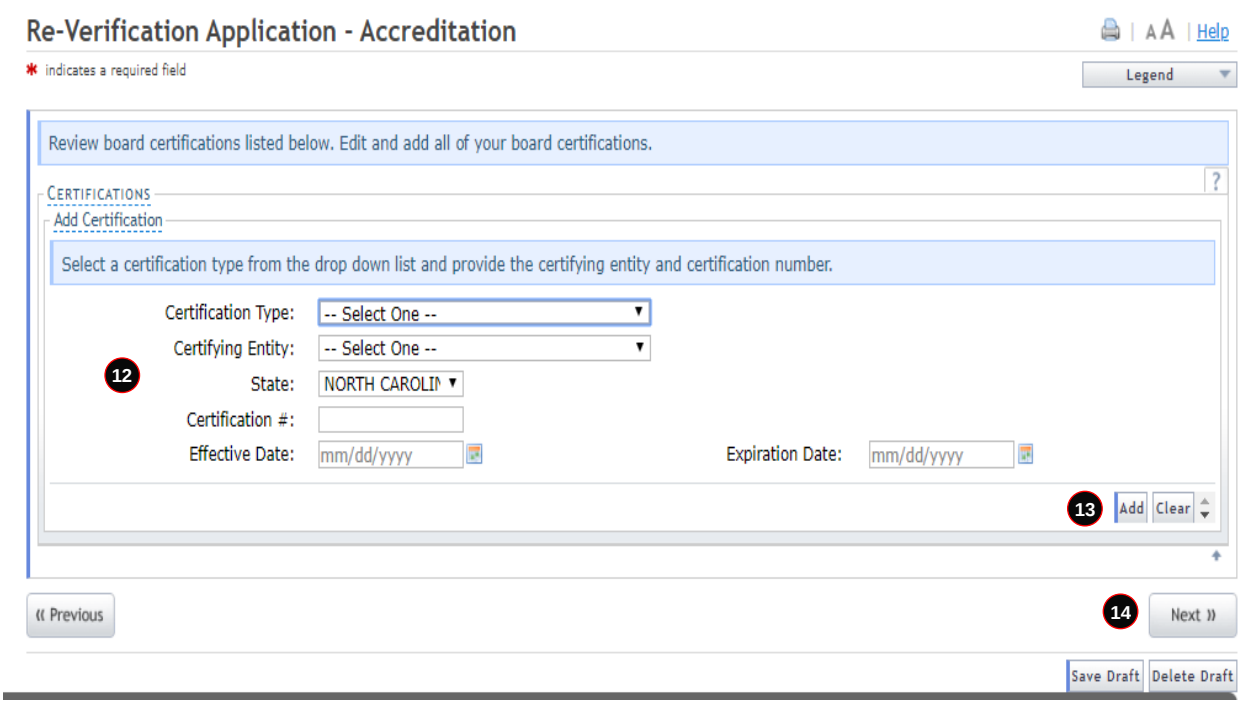
Step	Action
9	Select **Edit** to update the owner's information or to end-date the person if they are no longer an owner of the organization. **Note**: All changes will need to be saved after information has been altered.
10	Select **Next**.

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



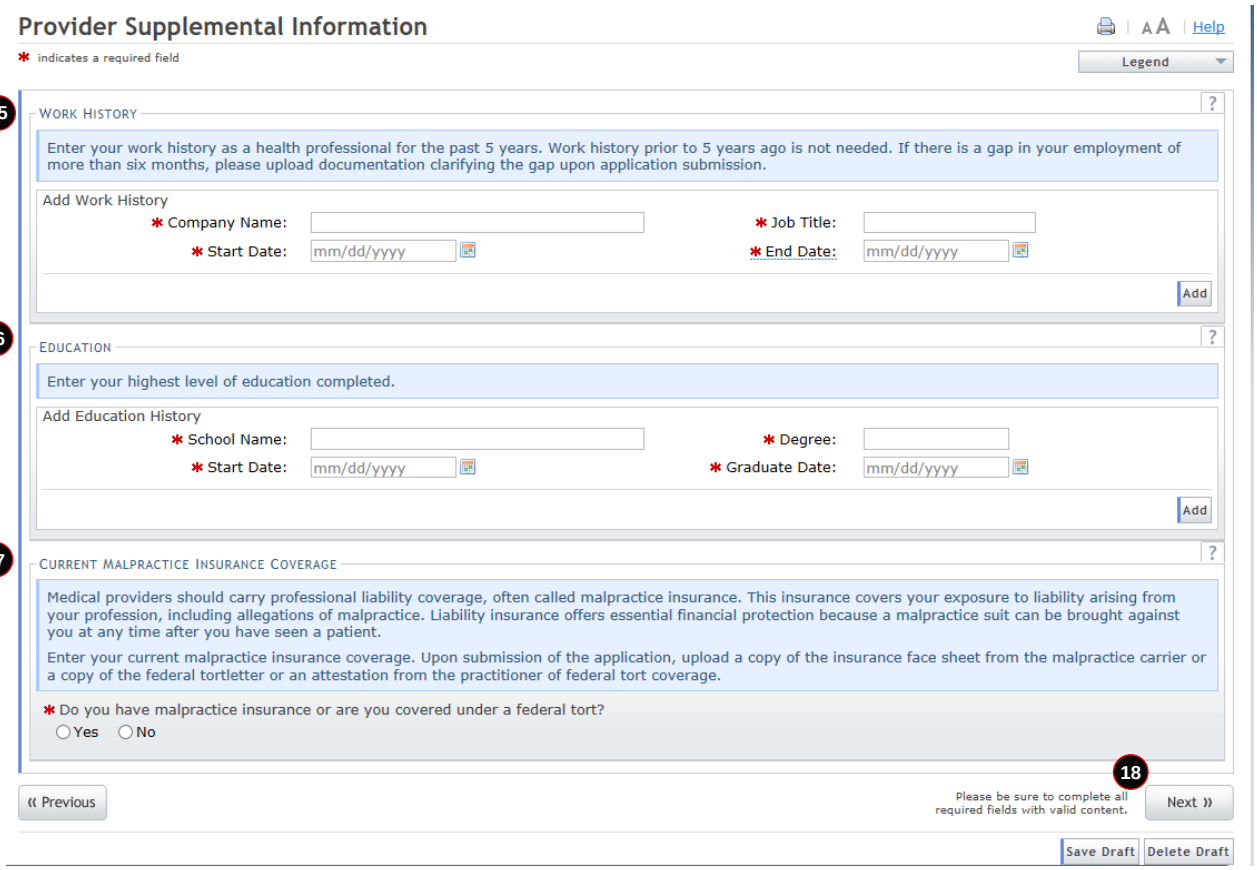
Step	Action
11	Select **Edit** to update the Managing Employee's information or to end-date the person if they no longer hold that role within the organization. **Note**: All changes will need to be saved after information has been altered.

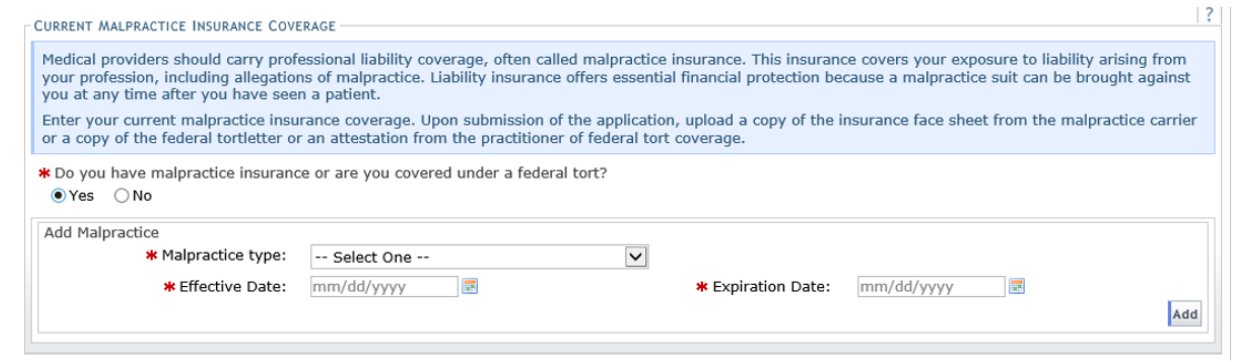
The **Re-verification Application – Accreditation** page displays for Individual providers only.

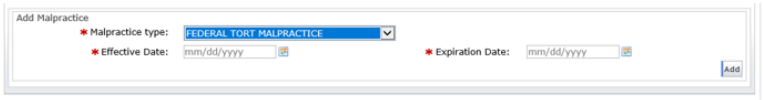


Step	Action
12	Review, edit, and/or enter your board certifications information such as Drug Enforcement Agency (DEA) certifications. • Certification Type • Certifying Entity • State – Select the state in which you are certified from the drop-down menu. • Certification # • Effective Date • Expiration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

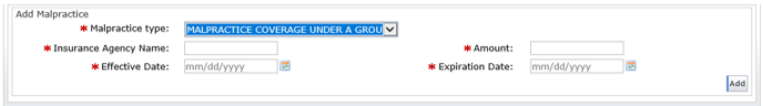
The **Provider Supplemental Information** page displays for Individual providers only.


Provider Supplemental Information
Help
* indicates a required field
Legend
15
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
16
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
17
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
18
« Previous
Please be sure to complete all required fields with valid content.
Next »
Save Draft
Delete Draft


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
Add Malpractice
* Malpractice type: -- Select One --
* Effective Date: mm/dd/yyyy
* Expiration Date: mm/dd/yyyy
Add

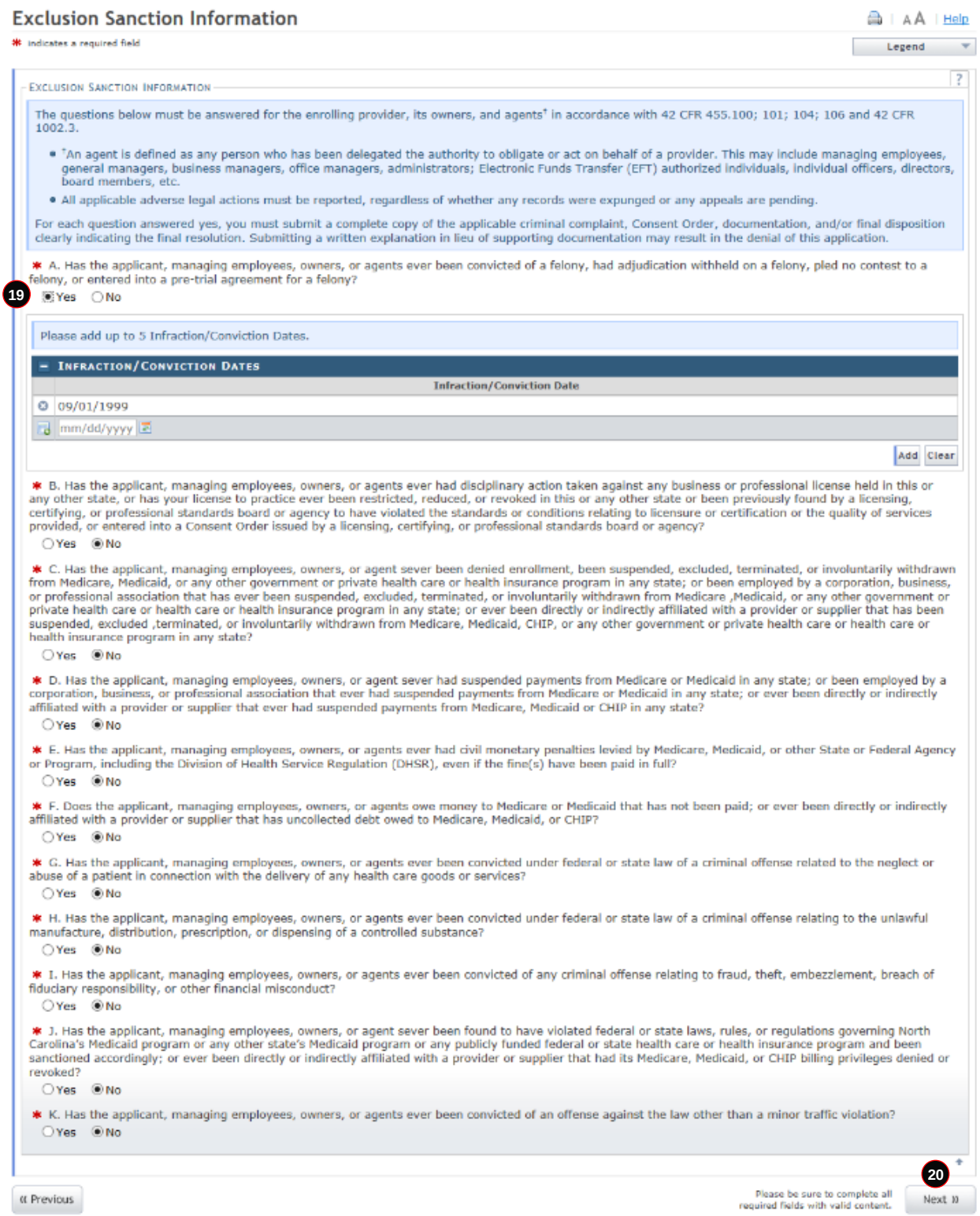

Add Malpractice
* Malpractice type: FEDERAL TORT MALPRACTICE
* Effective Date: mm/dd/yyyy
* Expiration Date: mm/dd/yyyy
Add


Add Malpractice
* Malpractice type: INDIVIDUAL MALPRACTICE COVERAGE
* Insurance Agency Name:
* Amount:
* Effective Date: mm/dd/yyyy
* Expiration Date: mm/dd/yyyy
Add


Add Malpractice
* Malpractice type: MALPRACTICE COVERAGE UNDER A GROU
* Insurance Agency Name:
* Amount:
* Effective Date: mm/dd/yyyy
* Expiration Date: mm/dd/yyyy
Add

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.



Exclusion Sanction Information

Help

* indicates a required field

Legend

EXCLUSION SANCTION INFORMATION

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

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

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

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

19 (Yes) (No)

Please add up to 5 Infraction/Conviction Dates.

INFRACTION/CONVICTION DATES

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

Add Clear

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

(Yes) (No)

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

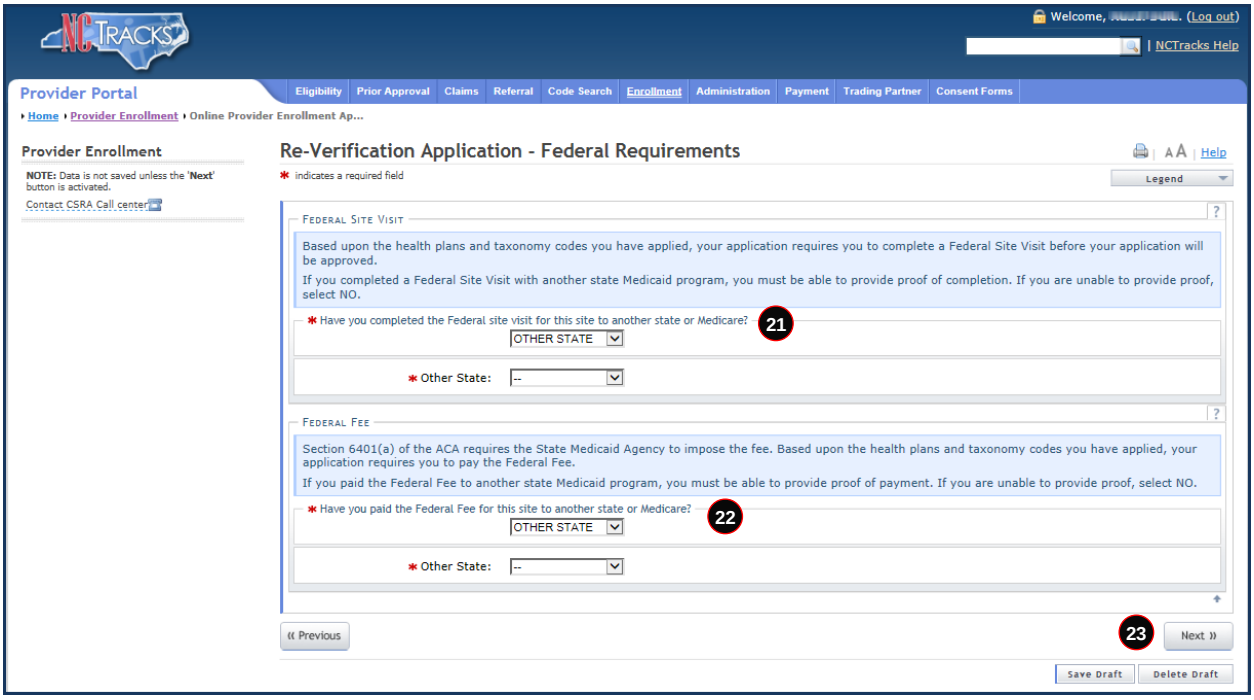
« Previous

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

20 Next »

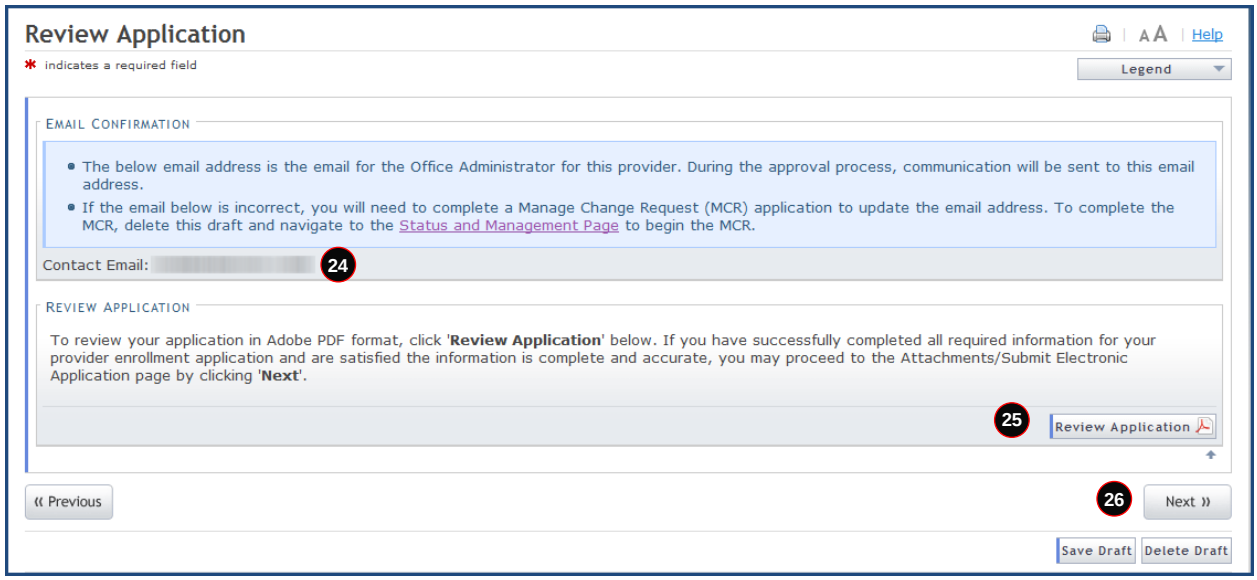
Step	Action
19	Answer each question by selecting the **Yes** or **No** radio button. **Note**: • These questions pertain to all providers, owners, and managing employees listed in the provider record. • When **Yes** is selected for a question, the **Infraction/Conviction Dates** section displays. Select 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 Appendix A of this document to learn more. • **Delete Draft:** Will delete the application, and the NPI 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.



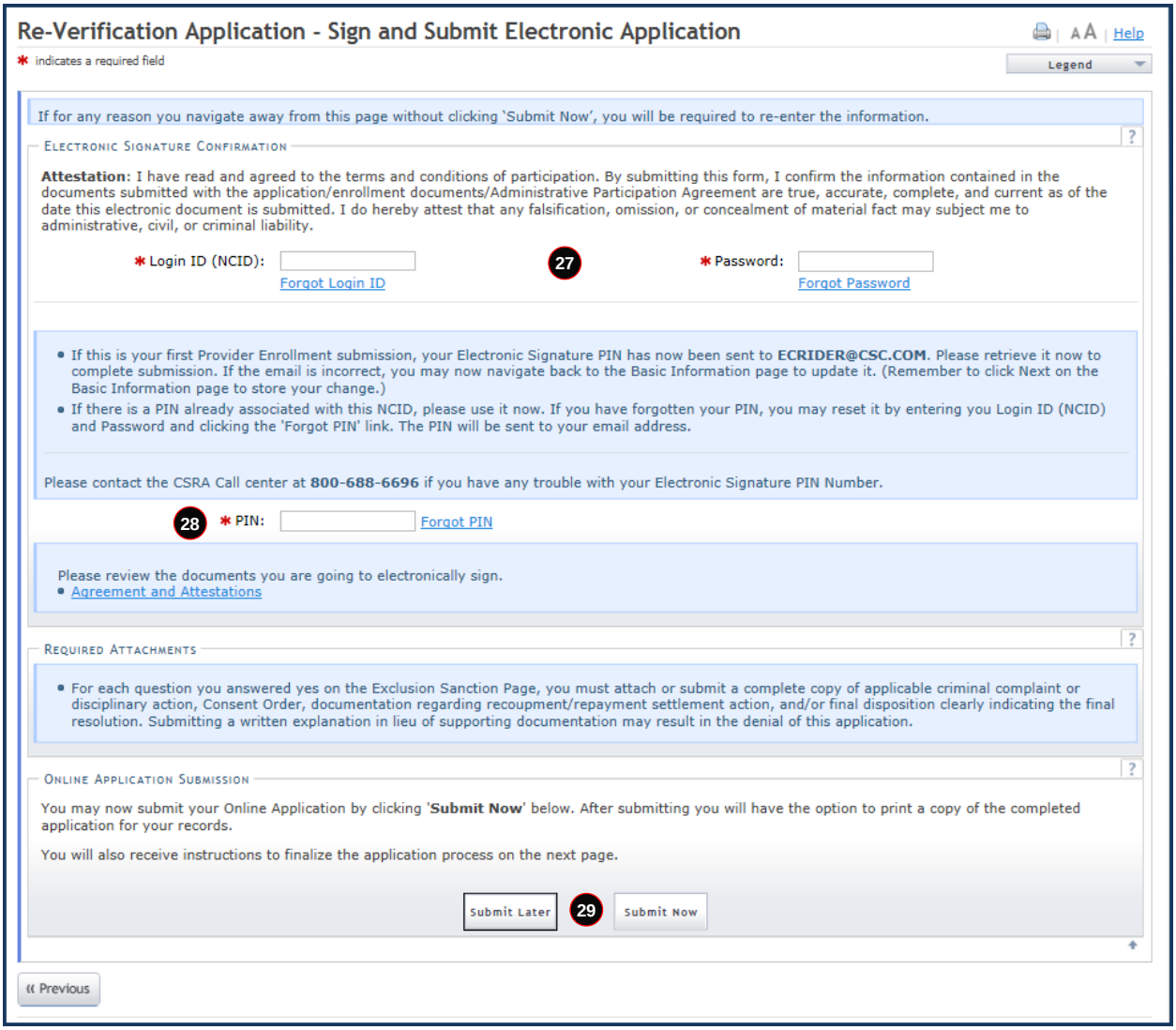
Step	Action
21	Answer the question **'Have you completed the Federal site visit for this site to another state or Medicare?'**. • Answer **No** – If you have not had a site visit or are unable to provide proof of completion. • Answer **Medicare** – If you have had a site visit for Medicare certification 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.



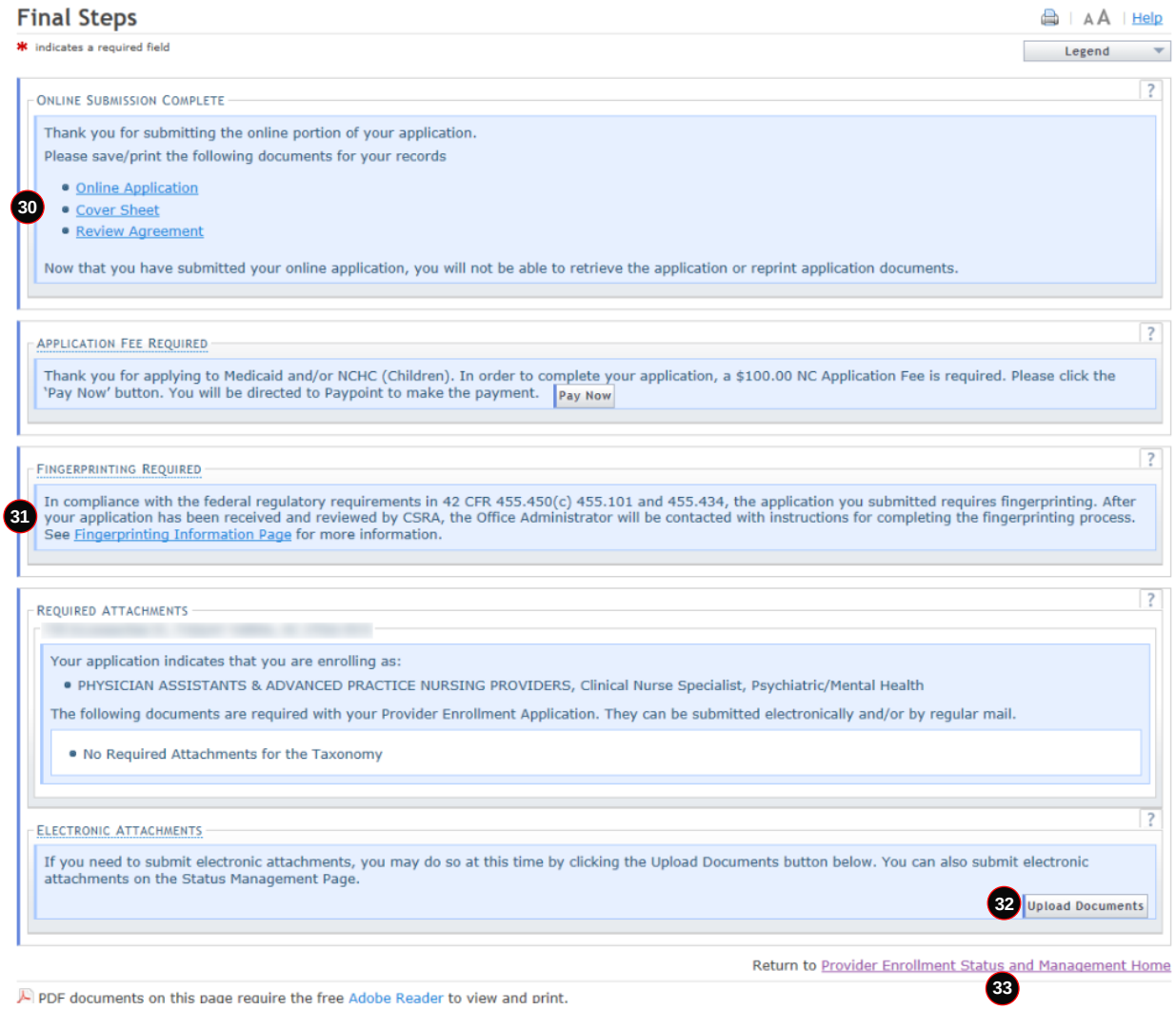
Step	Action
24	Verify the contact e-mail address listed on the page. **Note**: This e-mail address can be updated on the **Basic Information** page.
25	Select the **Review Application** button to review the application in Adobe PDF format. The application is a PDF document presenting all the information 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.



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.

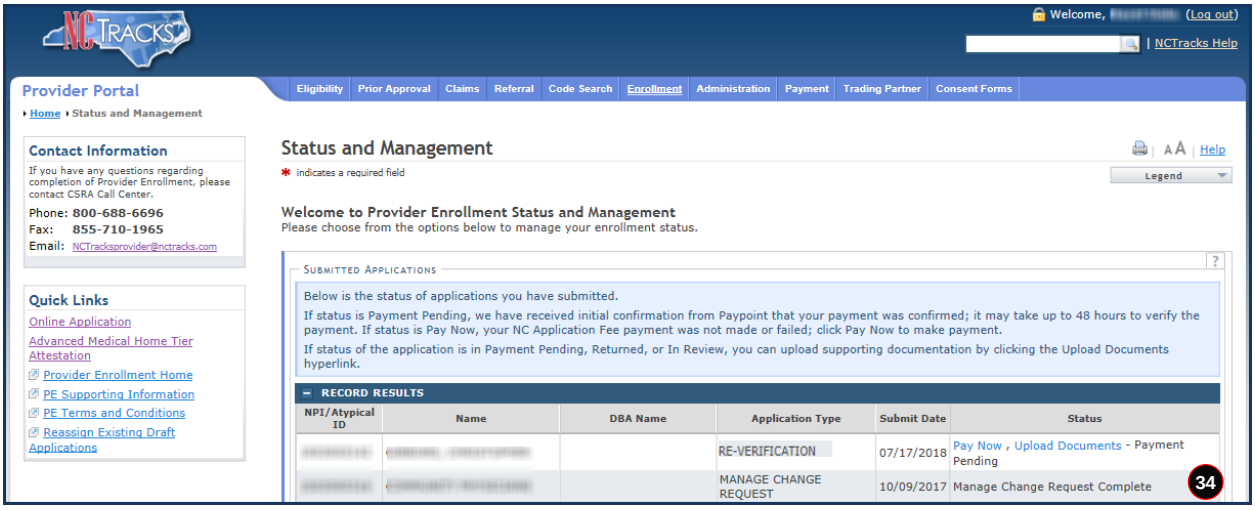
The **Final Steps** page displays.



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.

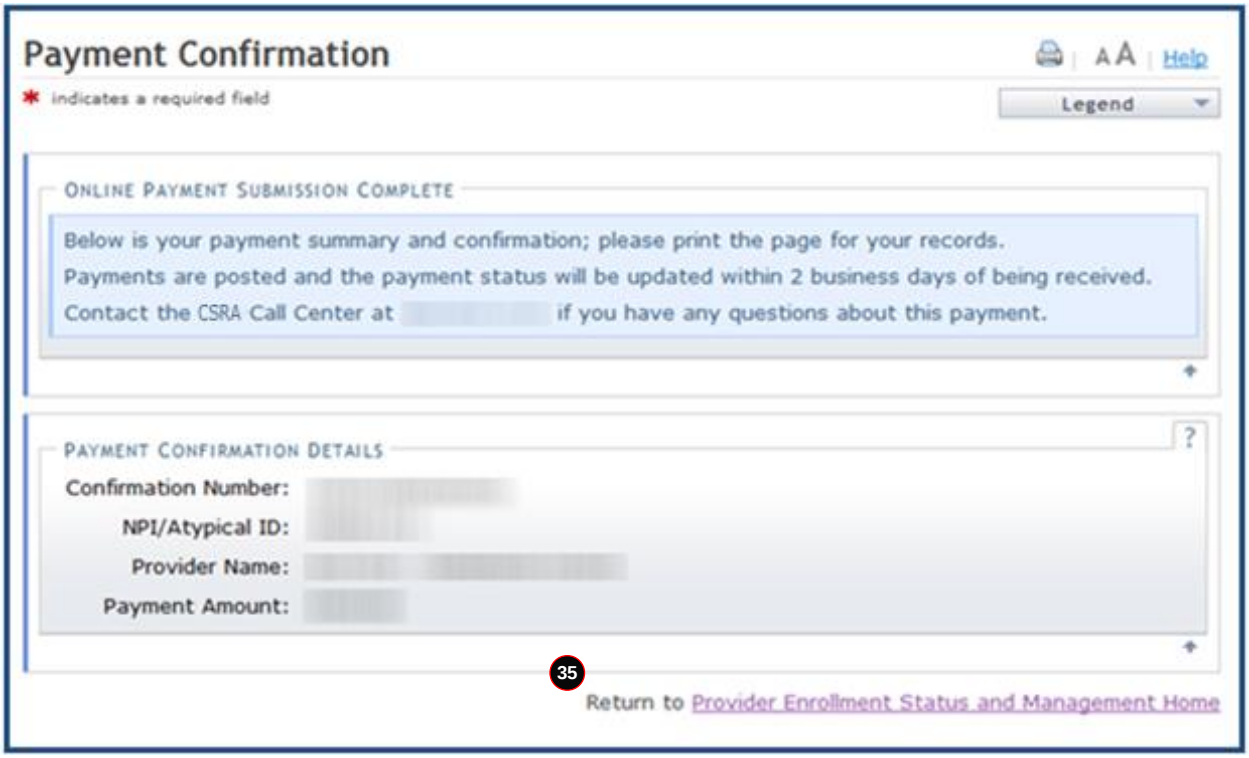
The **Status and Management** page displays.



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.

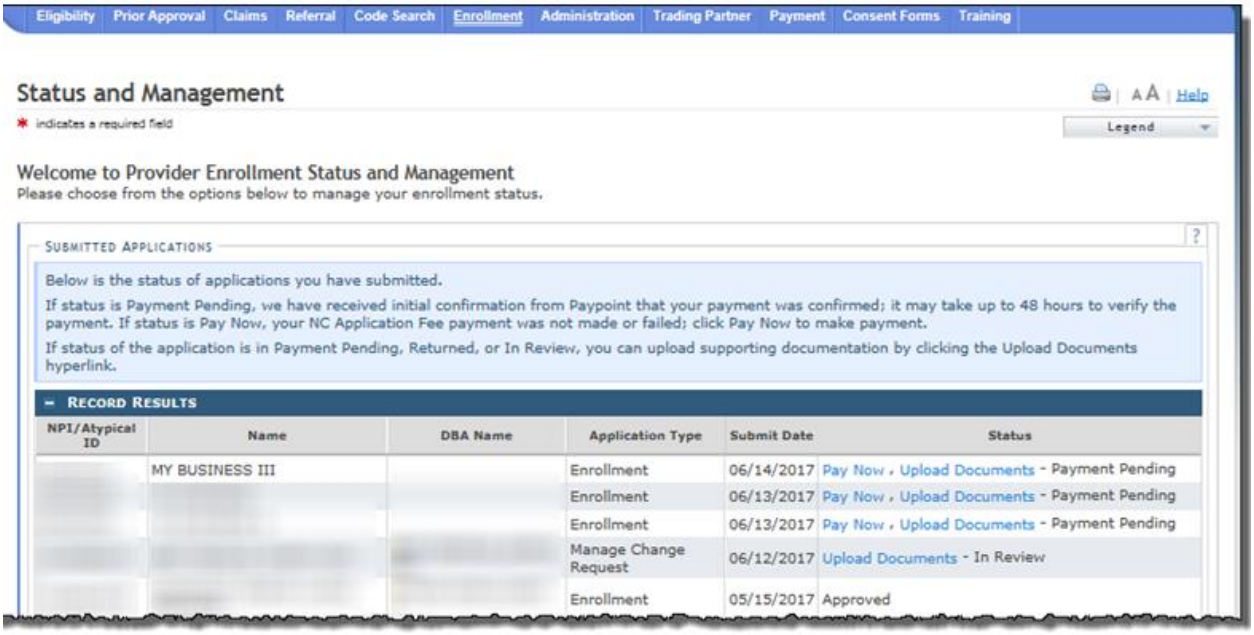


Step	Action
35	Select the **Provider Enrollment Status and Management Home** hyperlink to exit the page and complete the Re-verification process.

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.

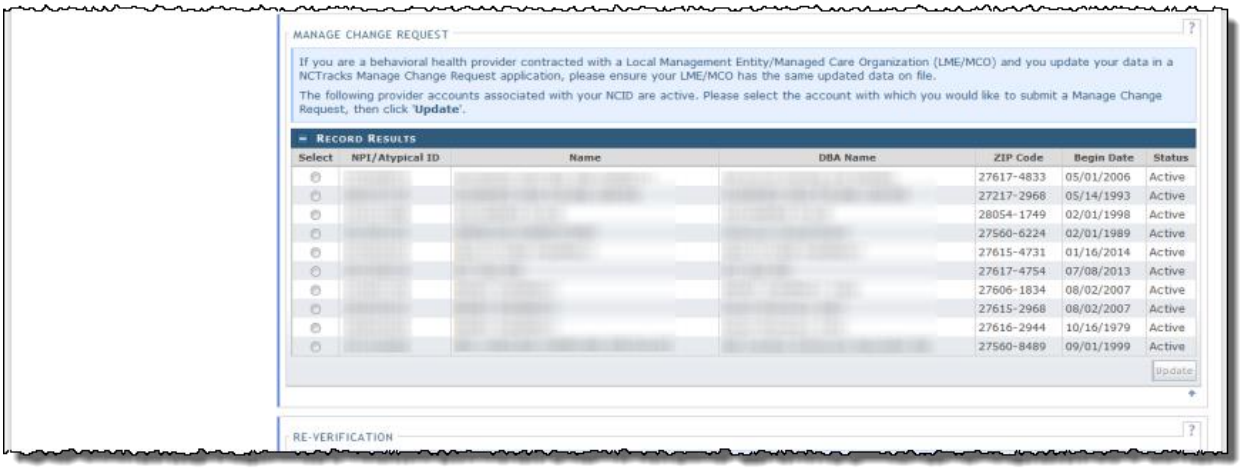


SAVED APPLICATIONS SECTION

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**.

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**.



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**.