Carolinas Medical Center
NorthEast

MEDICAID FORMS

Carefully Follow this Instructions Cover Sheet:

Answer the questionnaire and sign the signature page – do not date the signature.

You can initial and date this cover page:

_____ _____

Return forms to Jennifer Lambert:
CMC-NorthEast c/o NEPN Administration
845 Church Street N, Suite 310
Concord, NC 28025-4375

The full Medicaid Provider Enrollment application consists of approximately 27 pages. To save time and resources, only the signature pages are enclosed. However, if you would like to read the agreements, visit: http://www.nctracks.nc.gov/provider/forms/index.html

Consent to Release Information

I understand that the North Carolina Division of Medical Assistance (DMA) and its representatives is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA and its representatives to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program's credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

Under the penalties of perjury, I certify that:

1. The payee's Taxpayer Identification Number (disclosed on Page 1 of this application) is correct.
2. The payee is not subject to backup withholding due to failure to report interest.
3. The payee is a U.S. person.

Signature of Authorization Required

Information Must Be Entered For The Agreement To Be Processed
I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

Signature of Applicant *	Date *

Print Name *	Title *

Exclusion Sanction Information *

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

* An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
* A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
* An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

For each question answered yes, the applicant must attach or submit a complete copy of the applicable criminal complaint, Consent Order, documentation, licensure action, suspension, penalty or recoupment notice, 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.

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

A.	Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, pled no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense?	Yes	No
B.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had disciplinary action taken against any business or professional license held in this or any other state, including licenses issued by the North Carolina Division of Health Service Regulation (NC DHSR) and endorsements issued by any Local Management Entity as that term is defined in N.C.G.S. 122C-115.4?	Yes	No
C.	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
D.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?	Yes	No
E.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had payments suspended by Medicare or Medicaid in any state?	Yes	No
F.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including NC DHSR, even if the fine(s) have been paid in full?	Yes	No
G.	Have Medicare or Medicaid in any state ever taken recoupment actions against you or any entity you are or were either an agent, owner, or managing employee of?	Yes	No
H.	Do you or any entity you are or were either an agent, owner, or managing employee of, owe money to Medicare or Medicaid that has not been paid in full?	Yes	No
I.	Have you 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
J.	Have you 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
K.	Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct?	Yes	No
L.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever 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 other publicly funded federal or state health care or health insurance program?	Yes	No