# MEDICAID ENROLLMENT PACKET

**Follow the steps below. This will prevent errors which will delay enrollment.**

**Physicians Only:**

1. Answer the one page questionnaire
2. **SIGN EACH FORM** where it indicates "Signature of Applicant" - "Signature of Provider" – "Signature of Individual"
   *No stamped or copied signatures!*
   *There are a few duplicate pages; this is intentional!*
   *Do not sign in the shaded sections!*
3. For each line indicating ***Print Name and Title***, this should reflect the provider name as it appears on their license

   - **DO NOT DATE** the forms
   - **DO NOT fill in** telephone number, address info, NPI, address, or any other information at all. *I have to fill in the data so that it matches the group record exactly*!
   - **DO NOT EDIT or ALTER,** such as strike-through, white out, or initialing the forms. If you make a mistake, print a new set to sign!

   Mail the originally signed forms to:
   NEPN Administration
   ATTN: Jennifer Lambert
   845 Church St N, Suite 310
   Concord, NC 28025

   *Enclosed is a sample to help clarify the above.*

**PROVIDER MUST ANSWER QUESTIONS BELOW:**

**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 |

## 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 * |
|---|---|
| Jane Doe NP | |

| Print Name * | Title * |
|---|---|
| JANE DOE | N.P. |



* Required Fields

NC DHHS Provider Administrative Participation Agreement

Required Fields are marked with an asterisk (*).

**ONLY PRINT/SIGN NAME IN THE BOTTOM SECTION BELOW!**

*Medicaid Provider Name (Last, First, Middle or Organization Name)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

*Street Address Line 2 *Phone Number

*City *State *Zip Code + Four (Last 4 digits required)

*Correspondence Address Line 1 (Accounting)

*Correspondence Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

* Medicaid Provider Number (if applicable)

I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

Jane Doe

*Signature of Applicant or Authorized Agent *Date

JANE DOE N.P.

*Printed Name and Title

**DHHS/DMA/FISCAL AGENT APPROVAL**

*Signature *Date

Letter of Attestation

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance

**ONLY PRINT/SIGN NAME IN THE BOTTOM SECTION BELOW!**

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

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. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

Jane Doe

*Signature of Applicant or Authorized Individual *Date

JANE DOE N.P.

*Printed Name and Title

Required Fields are marked with an asterisk (*).

# North Carolina Department of Health and Human Services
## Division of Medical Assistance
## PROVIDER CERTIFICATION FOR SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

A separate certification is required for each individual in the group in addition to the group certification.

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. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

**ONLY PRINT/SIGN NAME IN THE BOTTOM SECTION BELOW!**

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

Jane Doe

*Signature of Applicant or Authorized Individual *Date

JANE DOE N.P.

*Printed Name and Title

**DMA/FISCAL AGENT APPROVAL**

Acceptance Date: _____ by _____

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

**ONLY PRINT/SIGN NAME IN THE BOTTOM SECTION BELOW!**

*Provider Name: _____

(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Medicaid Provider Number | *National Provider Identifier (NPI)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City | *State | *Zip Code + Four (Last 4 digits required)

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. An original signature by the individual applicant is required.

Jane Doe

*Signature of Applicant | *Date

JANE DOE N.P.

*Printed Name and Title

**DMA/FISCAL AGENT APPROVAL**

Acceptance Date | by

# North Carolina Department of Health and Human Services
# Medicaid Provider Change Form

**For assistance completing this application, please call the CSC EVC Operations Center at 866-844-1113.**

**ONLY PRINT/SIGN NAME IN SECTION #5 BELOW!**

☐ **Delete (unaffiliate) an individual** outpatient therapy practitioner, physician, or advanced practice nurse from the CABHA.

| Provider Name | Medicaid Provider Number | NPI | End Date |
|---|---|---|---|
| | | | |

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be deleted.

☐ Outpatient Therapy ☐ Medication Management ☐ Comprehensive Clinical Assessment

☐ **Add (affiliate) an attending service** to be provided by the CABHA.
*To add an attending provider for a service, please complete the CABHA Addendum to Add Attending Services at* http://www.nctracks.nc.gov/provider/providerEnrollment/.

☐ **Delete (unaffiliate) an attending service** provided by the CABHA.

| Attending Provider Name | Medicaid Provider Number | NPI | End Date |
|---|---|---|---|
| | | | |

Please identify the CABHA service provided by the attending provider to be deleted.

☐ Assertive Community Treatment Team
☐ Child and Adolescent Day Treatment
☐ Child Residential Level II-Family/Program Type, III, or IV
☐ Community Support Team
☐ Intensive In-Home
☐ Multi-Systemic Therapy
☐ Opioid Treatment
☐ Partial Hospitalization
☐ Psychosocial Rehabilitation
☐ Substance Abuse Comprehensive Outpatient Treatment Program
☐ Substance Abuse Intensive Outpatient Program
☐ Substance Abuse Medically Monitored Community Residential Treatment
☐ Substance Abuse Non-Medical Community Residential Treatment
☐ Therapeutic Family Services
☐ Targeted Case Management for Mental Health and Substance Abuse
☐ Peer Support

**5. Signature**

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. Individual provider changes must have the provider's signature. Authorized agents can only sign for a group change.

Jane Doe

Signature of Individual or Authorized Agent _____ Date _____

JANE DOE _____ N.P. _____

Printed Name _____ Title _____ Phone Number _____

**Mail this form to: CSC EVC Operations Center, P.O. Box 300020, Raleigh, NC 27622-8020 or fax to 866-844-1382.**

# North Carolina Department of Health and Human Services
# Medicaid Provider Change Form

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**5. Signature**

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Jane Doe

Signature of Individual or Authorized Agent | Date

JANE DOE | N.P. | Phone Number

Printed Name | Title

**Mail this form to: CSC EVC Operations Center, P.O. Box 300020, Raleigh, NC 27622-8020 or fax to 866-844-1382.**

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

**ONLY PRINT/SIGN NAME IN THE BOTTOM SECTION BELOW!**

*Provider Name: _____

(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

## Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

| *Provider Name | *Provider Medicaid Number | *Signature of Provider |
|---|---|---|
| JANE DOE N.P. | | Jane Doe |
| | | |
| | | |
| | | |
| | | |

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|---|---|---|
| JANE DOE N.P. | | Jane Doe |
| | | |
| | | |
| | | |
| | | |

CMC-NorthEast
NEPN

# SIGNATURE VERIFICATION FORM

Please **Print** Provider Full Legal Name: _____

Attach this form to the enclosed signature pages/applications and return to:

CMC-NorthEast, NEPN
845 Church Street N, Suite 310
Concord, NC 28025-4375
ATTN: Jennifer Lambert

**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.
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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 |

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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.

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2. The payee is not subject to backup withholding due to failure to report interest.
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## Signature of Authorization Required

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| Signature of Applicant * | Date * |
|---|---|
| | |

| Print Name * | Title * |
|---|---|
| | |

NC DHHS Provider Administrative Participation Agreement

Required Fields are marked with an asterisk (*).

*Medicaid Provider Name (Last, First, Middle or Organization Name)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

*Street Address Line 2 *Phone Number

*City *State *Zip Code + Four (Last 4 digits required)

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*City *State *Zip Code + Four (Last 4 digits required)

* Medicaid Provider Number (if applicable)

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*Signature of Applicant or Authorized Agent *Date

*Printed Name and Title

**DHHS/DMA/FISCAL AGENT APPROVAL**

*Signature *Date

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I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

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*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

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Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

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I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

A separate certification is required for each individual in the group in addition to the group certification.

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. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

_____

*Signature of Applicant or Authorized Individual *Date

_____

*Printed Name and Title

**DMA/FISCAL AGENT APPROVAL**

Acceptance Date: _____ by _____

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name: _____

(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Medicaid Provider Number | *National Provider Identifier (NPI)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City | *State | *Zip Code + Four (Last 4 digits required)

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. An original signature by the individual applicant is required.

*Signature of Applicant | *Date

*Printed Name and Title

**DMA/FISCAL AGENT APPROVAL**

Acceptance Date | by

☐ **Delete (unaffiliate) an individual** outpatient therapy practitioner, physician, or advanced practice nurse from the CABHA.

| Provider Name | Medicaid Provider Number | NPI | End Date |
|---|---|---|---|
| | | | |

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be deleted.

☐ Outpatient Therapy ☐ Medication Management ☐ Comprehensive Clinical Assessment

☐ **Add (affiliate) an attending service** to be provided by the CABHA.
*To add an attending provider for a service, please complete the CABHA Addendum to Add Attending Services at* http://www.nctracks.nc.gov/provider/providerEnrollment/.

☐ **Delete (unaffiliate) an attending service** provided by the CABHA.

| Attending Provider Name | Medicaid Provider Number | NPI | End Date |
|---|---|---|---|
| | | | |

Please identify the CABHA service provided by the attending provider to be deleted.

☐ Assertive Community Treatment Team
☐ Child and Adolescent Day Treatment
☐ Child Residential Level II-Family/Program Type, III, or IV
☐ Community Support Team
☐ Intensive In-Home
☐ Multi-Systemic Therapy
☐ Opioid Treatment
☐ Partial Hospitalization
☐ Psychosocial Rehabilitation
☐ Substance Abuse Comprehensive Outpatient Treatment Program
☐ Substance Abuse Intensive Outpatient Program
☐ Substance Abuse Medically Monitored Community Residential Treatment
☐ Substance Abuse Non-Medical Community Residential Treatment
☐ Therapeutic Family Services
☐ Targeted Case Management for Mental Health and Substance Abuse
☐ Peer Support

## 5. Signature

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. Individual provider changes must have the provider's signature. Authorized agents can only sign for a group change.

Signature of Individual or Authorized Agent _____ Date _____

Printed Name _____ Title _____ Phone Number _____

☐ **Delete (unaffiliate) an individual** outpatient therapy practitioner, physician, or advanced practice nurse from the CABHA.

| Provider Name | Medicaid Provider Number | NPI | End Date |
|---|---|---|---|
| | | | |

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be deleted.

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☐ Substance Abuse Non-Medical Community Residential Treatment
☐ Therapeutic Family Services
☐ Targeted Case Management for Mental Health and Substance Abuse
☐ Peer Support

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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. Individual provider changes must have the provider's signature. Authorized agents can only sign for a group change.

Signature of Individual or Authorized Agent _____ Date _____

Printed Name _____ Title _____ Phone Number _____

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Required Fields are marked with an asterisk (*).

*Provider Name: _____

(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

## Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

| ***Provider Name** | ***Provider Medicaid Number** | ***Signature of Provider** |
|---|---|---|
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15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name: _____

(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

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*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

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Street Address Line 2

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*City *State *Zip Code + Four (Last 4 digits required)

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| ***Provider Name** | ***Provider Medicaid Number** | ***Signature of Provider** |
|---|---|---|
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