North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Services Center
Raleigh NC 27699-2501
801Ruggles Drive
Raleigh NC 27603

Dear Applicant

Thank you for your interest in becoming a Community Intervention Services Agency provider with the NC Medicaid Program. In order for us to complete the enrollment process, you must receive endorsement prior to submitting the following:

Group Applicant

- Community Intervention Services Application
- North Carolina Division of Medical Assistance Medicaid Participation Agreement – All applicants must indicate they have read, understood and agreed to the rules and regulations governing Medicaid by signing and dating the NC Medicaid Participation Agreement. Original Signature Required. Agreement can not be altered.
- Electronic Claims Submission (ECS) Agreement – all applicants who wish to submit claims electronically must read, sign and date the ECS agreement.
- Provider Certification for Signature on File (if desired)
- W-9. Please reference complete instructions which have been supplied by the IRS.
- Copy of 'Articles' (of Incorporation, LLC, PLLC, etc. issued by Secretary of State)
- State, Local or County Business License (if applicable)
- Copy of Approval Letter by CDSA/DPH for Early Intervention Services (if applicable).
- Copy of Certificate of Accreditation (if applicable i.e. JCAHO, CARF).
- Copy of Notification of Endorsement Action by LME or Accreditation Letter issued by DPH.

Providers are requested to include on their application the name, e-mail address, and fax number of the individual at their site that is responsible for receiving Medicaid information.

Providers are assigned a provider number and are notified by mail once the enrollment process has been completed. Please do not submit claims for any services until you have received notification of your provider number, and its effective date. Billing information and medical coverage polices are available on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm.

Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your CIS Provider Enrollment Specialist at 1-919-855-4050. We are also on the Web at http://www.dhhs.state.nc.us/dma/

Instructions for Medicaid Direct Enrollment of Community Intervention Services (CIS) Agency

A prospective provider must apply for and be enrolled as a Medicaid provider with the NC Division of Medical Assistance (DMA) to qualify for reimbursement for Community Intervention Services. The enrollment process includes the following steps:

1. Provider completes and signs the enrollment packet and returns along with the required credentials to:

   DMA Provider Services
   Attn: CIS Provider Enrollment Specialist
   2501 Mail Services Center
   Raleigh, NC 27699-2501

2. If the packet is not completed properly, DMA will return the packet for correction or for additional information.
3. If the provider meets all qualifications, DMA assigns a core group provider number and applicable attending numbers, which must be entered in all claims for reimbursement of services rendered.
4. DMA sends the provider a letter with the provider number and a copy of the signed Medicaid Participation Agreement. If applicable, a copy of the Electronic Claims Submission (ECS) Agreement will be included.
5. The provider may begin billing upon receipt of the provider number and provider agreement.

Important Points to Remember

- Each site and service must obtain endorsement from the Local Management Entity (LME).
- All sites must have a different provider number.
- All parts of the CIS Provider Enrollment packet must be completed. Signature must be original. White out and alterations are not accepted. Please do not highlight any information on the enrollment packet.
- Copies of the applicable credentialing documentation must accompany the application. If these documents are missing, the application will be returned to the provider.
- Each group provider must submit a separate application for enrollment.
- Name on application must exactly match name on Medicaid Participation Agreement.

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

WE WILL NOT BE ABLE TO COMPLY IF US POSTAGE IS NOT AFFIXED.

Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501

PLACE STAMP HERE. POST OFFICE WILL NOT DELIVER WITHOUT PROPER POSTAGE.

_____
Name

_____
Address

_____
City State Zip Code

APPLICATION ACKNOWLEDGEMENT CARD

Dear Prospective Provider:

We have received your application for enrollment in the NC Medicaid Program.

DMA will notify you of your status via mail once the enrollment process has been completed, or in the event additional information is needed.

Thank you again for your interest in the NC Medicaid Program.

Sincerely,

DMA Provider Services

North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services - 919-855-4050
Community Intervention Services (CIS) Agency
Provider Enrollment Application

STATE USE ONLY
[ ] Initial Enrollment
[ ] Re-enrollment
[ ] CHOW
[ ] Other Change

Type of Application:

☐ Initial Request ☐ Re-enrollment*
☐ Change of Ownership*

* Medicaid Provider Number: _____

Type or Print All Information in Blue or Black Ink

Name of Provider (must exactly match the name on Medicaid Participation Agreement):

_____

Doing Business As (if applicable): _____

Telephone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

Email Address:_____

Site Address: _____
Street

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

County: _____

Payment/Mailing Address: _____
Street or Post Office Box

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

Contact Person's Name:_____

Contact Person's Telephone Number: (_____) _____

Medicare Number_____

National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

Taxonomy: ☐☐☐☐☐☐☐☐☐X
☐☐☐☐☐☐☐☐☐X
☐☐☐☐☐☐☐☐☐X

A. List all shareholders/partners (including self) who have 5% or more ownership AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and information requested on each.

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

B. Have you, or individuals or organizations having a direct or indirect ownership or control interest of five percent (5%) or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX) or Social Services Block Grant (XX)?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

C. Have any of your directors, officers, agents or managing employees of your group been convicted of a criminal offense related to their involvement in the program of Medicaid, Medicare or Social Services Block Grant?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

D. Have civil monetary penalties ever been levied against this agency by Medicare, Medicaid or other State or Federal Agency or Program?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

E. Have you or any of the individuals listed in Item 'A' ever:

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?
☐ **Yes** ☐ **No**

If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition:

_____

_____

b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?
☐ **Yes** ☐ **No**

If 'Yes' to 'E b', complete below and attach a copy of the final disposition. Attach documentation from the proper authorities that approve the reinstatement of the license:

Against Whom?	Action Taken?	Who took Action?	Date of Action?

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?
☐ **Yes** ☐ **No**

If 'Yes', list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that had suspended payments from Medicare or Medicaid in any state?
☐ **Yes** ☐ **No**

e. Owes money to Medicaid or Medicare that has not been paid?
☐ **Yes** ☐ **No**

F. Is the organization/agency incorporated?
☐ **Yes** ☐ **No**
If yes, please attach a copy of Application for Incorporation, copy of Certified Articles of Incorporation and any subsequent changes to the Application/Articles of Incorporation.

G. In what specific locations or areas of the state will the services (s) be provided?

_____

_____

H. Is the agency, organization or individual provider(s) licensed, certified, accredited, or approved by any professional organization or Board?
☐ **Yes** ☐ **No**
If yes, please attach copy of license, certification, accreditation, permit, approval, etc.

J. Indicate what Community Intervention Services your business/agency will be providing:

- ☐ Assertive Community Treatment Team
- ☐ Community Support Services
- ☐ Partial Hospital
- ☐ Mobile Crisis Management
- ☐ Intensive In Home
- ☐ Child and Adolescent Day Treatment
- ☐ Psychosocial Rehabilitation
- ☐ Community Based Rehabilitative Service – Early Intervention
- ☐ Professional Treatment Services in Facility Based Crisis Programs
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Non Medical Community Residential Treatment
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse comprehensive Outpatient Treatment Program
- ☐ Medically Supervised or ADATC Detoxification/Crisis Stabilization
- ☐ DD Targeted Case Management
- ☐ Ambulatory Detoxification
- ☐ Non Hospital Detoxification
- ☐ Opiod Treatment
- ☐ Diagnostic Assessment
- ☐ Multisystemic Therapy (MST)

Signature Authorization Required

****UNSIGNED APPLICATION WILL NOT 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. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

Signature of Applicant or Authorized Agent **Date**

_____

Printed Name and Title

Additional Taxonomy:

									X
									X
									X
									X
									X
									X
									X
									X
									X
									X
									X
									X

STATE USE ONLY
[ ] Initial Enrollment
[ ] Re-enrollment
[ ] CHOW
[ ] Other Change

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
MEDICAID PARTICIPATION AGREEMENT

2501 Mail Service Center Raleigh, N.C. 27699-2501 Ph. 9l9-855-4050

_____ (_____)_____
Provider Name (must exactly match name on application) Phone No.

_____
Site address: Street City State Zip + Four Digits

_____
Payment/Mailing address: Street City State Zip + Four Digits

_____ (_____)_____
Name and e-mail address of contact person Fax No.

A. The aforementioned provider agrees to participate in the North Carolina Medicaid Program and agrees to abide by the following terms and conditions:

1. Comply with federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement (including, but not limited to, Medicaid provider manuals and Medicaid bulletins published by the Division of Medical Assistance and/or its fiscal agent).

2. Provide services to Medicaid eligible recipients of the same quality as are provided to private paying individuals without regard to race, color, age, sex, religion, disability, or national origin.

3. Accept as payment in full, the amounts paid by the Medicaid Program except for payments from legally liable third parties and authorized cost sharing by recipients.

4. Not charge the patient or any other person for items and services covered by the Medicaid Program and to refund payments made by or on behalf of the patient for any period of time the patient is Medicaid approved, including dates for which the patient is retroactively entitled to Medicaid.

5. Maintain for a period of five (5) years from the date of service: (a) accounting records in accordance with generally accepted accounting principles and Medicaid recordkeeping requirements; and (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program. For providers who are required to submit annual cost reports, “records” include, but are not limited to, invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, etc. Such records are subject to audit and review by Federal and State representatives.

6. On request, furnish to the Division of Medical Assistance (DMA) and its agents, the Centers for Medicare and Medicaid Services (CMS), or the State Medicaid Fraud Control Unit of the Attorney General's Office, any information or records, including records of any outside entities, contractors, or subcontractors for costs related to services provided to Medicaid patients and billed to the Medicaid Program.

7. Assure that items or services provided under arrangements or contracts with outside entities and professionals meet professional standards and principles and are provided promptly. Such arrangements must include provision for access and audit of records by state and federal representatives as stated in item 6 above as are necessary to establish the amounts actually billed to and collected from the provider.

8. Determine responsibility and bill all appropriate third parties prior to billing the Medicaid Program. Upon receipt of payments from third parties subsequent to reimbursement by the Medicaid Program, promptly refund such prior payments.

9. Under penalty of perjury, inform DMA of provider tax identification name, address and number at the time of enrollment and for subsequent changes and be liable for any withholding or penalties required by IRS regulations.

B. PROVIDER FURTHER UNDERSTANDS AND AGREES:

1. Payment of claims is from State, Federal and County funds and any false claims, false statements or documents, or misrepresentation or concealment of material fact may be prosecuted by applicable State and/or Federal law.

2. DMA may withhold payment because of irregularity from whatever cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the provider and/or DMA and its agents.

3. If any part of this agreement is found to be in conflict with any Federal or State laws or regulations having equal weight of law, or if any part is placed in conflict by amendment of such laws, this agreement is so amended except that if the fulfillment of this agreement on the part of either party is rendered unfeasible or impossible, both the provider and DMA shall be discharged from further obligation under the terms of this agreement, except for equitable settlement of the respective debts up to the date of termination.

4. Neither providers nor employees thereof shall use or disclose information concerning Medicaid patients, including name and address, social and economic conditions or circumstances, medical data and medical services provided, except for purposes of rendering necessary medical care, arranging for medical care or services not available from the provider, establishing eligibility of the patient, and billing for services of the provider. Neither patient records nor portions thereof may be transferred except by written consent of the patient or as otherwise provided by law.

5. That federal and/or State officials and their contractual agents may make certification and compliance surveys, inspections, medical and professional reviews, and audit of costs and data relating to services to Medicaid patients as may be necessary under Federal and State statutes, rules and regulations. Such visits must be allowed at any time during hours of operation, including unannounced visits. All such surveys, inspections, reviews and audits will be in keeping with both legal and ethical practice governing patient confidentiality.

6. That billings and reports related to services to Medicaid patients and the cost of that care must be submitted in the format and frequency specified by DMA and/or its fiscal agent.

7. That payment will be made in accordance with the approved Medicaid State Plan.

8. Neither this agreement nor the assigned provider number shall be transferable or assignable except as provided by Federal regulations.

9. This agreement may be terminated by the Provider upon giving thirty (30) days prior written notice to all parties to the agreement.

10. DMA may terminate this agreement upon giving written notice or refuse to enter into an agreement when:

    a. The provider fails to meet conditions for participation, including licensure, certification or other terms and conditions stated in the provider agreement, or

    b. The provider is determined to have violated Medicaid rules or regulations, or

    c. Any person with ownership or control interest in the provider agency or an agent or managing employee of the provider has been convicted of a criminal offense related to services provided under titles XVIII, XIX, or XX of the Social Security Act, or

    d. The provider fails to provide medically appropriate health care services, or

    e. The State determines it to be in the best interests of the State and Medicaid recipients to do so.

11. Claims may not be reassigned to an individual or organization that advances money to the provider of services 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.

C. The Community Intervention Service provider agency/organization certifies that it complies with and agrees to the following conditions:

1. To meet provider agency/organization standards established by the Division of Mental Health/Developmental Disability/Substance Abuse Services and/ or the NC Infant Toddler Program under the Early Intervention Branch of the Division of Public Health.

2. To maintain records that fully identify the costs of specified services reimbursed under the Medicaid Program for Medicaid recipients and to maintain confidentiality of recipient information, including financial circumstances and medical data. Such records shall be in accordance with privacy requirements of the Family Educational Rights and Privacy Act (FERPA) and/or applicable Health Insurance Portability & Accountability Act, effective April 2003.

3. To assume fiscal responsibility to employed and contracted providers for costs of specified services rendered for Medicaid reimbursement under this agreement. To assure fiscal control for accounting procedures adopted to ensure proper distribution and accounting for funds paid under the Medicaid Program. To ensure that the administrative activities are reasonable and directly necessary for the administration of the Medicaid Program.

4. To participate in the Quality Assurance and review processes or activities as defined by the LME or CDSA agency with the administrative oversight authority of CIS services rendered by the provider agency or organization.

5. To provide only those CIS (community based) services ordered by a primary care physician, psychiatrist or licensed practicing psychologist under the service order specifying level of CIS service(s) to be rendered.

6. To provide or implement ordered services as defined within the most current Medicaid approved service definition(s) and as outlined in the Person Centered (PCP)/Individual Family (IFSP) service plan.

7. To assure all services, activities or interventions are delivered by qualified professional practitioners within the requirements of the staff definitions defined in the appropriate rule(s) for the disability population being served. Practitioners shall meet the qualified professional status requirements as defined in 10 NCAC 27G.0104 or the NC Infant Toddler Program Personnel Certification as defined in the APSM 120-1.

8. That supervision of services rendered shall meet specifications according to 10 NCAC G.0104 or Part C of the IDEA standards of competence related to licensure/certification requirements for the appropriate discipline (s).

9. To maintain professional liability insurance with minimal limits of 1 million per occurrence and 3 million aggregate. Said insurance shall remain in effect throughout the duration of the providers' participation in the Medicaid program.

10. Provider agency/organization and or practitioners shall maintain all professional, business and state licensures in good standing for the duration of participation in the Medicaid program. Services requiring a license may not be rendered or billed to the Division of Medical Assistance, Medicaid in the event licensure is not active or in good standing.

11. Persons, organizations, agencies or assigns providing Medicaid services shall submit to the Division of Medical Assistance all information concerning the ownership and or controlling interest of the enrolled entity. Notification shall be provided to the Division of Medical Assistance concerning any changes to the organization's structure, status, ownership or ownership interest throughout the duration of participation in the Medicaid program. Provider shall notify, report and supply full disclosure of such information timely to Medicaid. Changes may require, at the discretion of the Medicaid program, that a new enrollment and participation agreement be executed when ownership or controlling interest are changed.

12. Provider agency/organization and/or practitioners shall maintain all professional, business and state licensures in good standing for the duration of participation in the Medicaid program. Services requiring a license may not be rendered or billed to the Division of Medical Assistance, Medicaid in the event licensure is not active or in good standing.

13. Provide full and accurate disclosure to the Division of Medical Assistance of any prior violation(s), fines(s), penalties, suspension, termination or fiscal action taken against the provider agency/organization, it's contractors, owners or controlling interest parties under federal and state laws and/or rules that govern the medical assistance program, Medicare or other regulatory bodies.

14. That all Medicaid services rendered by arrangement or contract with outside entities with the provider agency/organization herein do not imply a contractual agreement between said agencies and Medicaid. The enrolled provider agency/organization shall remain responsible to Medicaid for fiduciary, administration of the services and terms of this agreement.

Signature of Authorization Required:

****UNSIGNED AGREEMENT WILL NOT 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. Individual agreements must have the provider's original signature. Authorized agents can only sign for group agreements.

_____	_____
Signature of Applicant or Authorized Agent	**Date**
_____	_____
Printed Name and Title	**Fiscal Year End Date**

INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provider services of which are in accordance with the approved services definitions.

DMA APPROVAL:
Accepted on _____ by _____

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
INSTRUCTIONS FOR COMPLETING THE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

Carefully read the ECS Agreement in its entirety. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims. The ECS Agreement is not transferable from one group practice to another, from one owner of a practice/facility to another or for members of a group moving to another group or solo practice. The Agreement may not be altered or marked in any way. Photo or fax copies are not accepted. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

1. Type or print in black ink and **return all copies** to the **Division of Medical Assistance**. Do not separate the copies.

2. Upon DMA approval, a signed copy will be returned to the provider. **Claims should not be submitted electronically until there is an approved ECS Agreement and transmission has been tested with EDS (DMA's fiscal agent).**

3. Provider Business Name
   a. Enter the name of the business/practice/facility or the name of the practitioner if the business is a solo practice.
   b. If you are currently enrolled in the N.C. Medicaid program, the provider name entered on the Agreement must match the name on the Remittance and Status Report.
   c. If the name of the business/practice/facility has changed since enrollment, attach an explanation or call the DMA Provider Services Unit at 919-855-4050.

4. Mailing Address – Enter the address for receipt of mail if different from the site address. If either address has changed and DMA has not been notified, please attach an explanation. If the addresses on the Agreement do not match those in DMA's provider files, the ECS Agreement will be returned.

5. Signature – Original signatures are required. Signature stamps are not acceptable.
   a. The signature of the provider is required for solo practitioners and partnerships.
   b. The owner, business officer or an individual who has authority to enter into contracts on behalf of the provider organization must sign the Agreement.
   c. An authorized agent such as the medical director, owner, vice president, business officer, etc., who has the authority to enter into contracts on behalf of the group must sign for the group.
   d. When new members join a group that **already has an ECS Agreement**, simply complete page three and **add the new providers' signatures only**. Current providers do not have to sign the Agreement again.

6. Provider Number – List the number to which Medicaid payment is to be made.

7. Completion of the bottom section on page three is required if filing under a group provider number, even if there is only one practitioner in the group.

8. Before submitting electronic claims, contact the ECS unit at EDS, 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) Electronic claims will not process until EDS activates authorization for ECS billing. The ECS Unit must assign an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to:

Provider Services
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

FEDEX OR UPS

1985 Umstead Drive
Raleigh NC 27603

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

Provider Services 2501 Mail Service Center Raleigh, NC 27699-2501 Ph. 919-855-4050

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

l. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify DMA in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to DMA prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to DMA. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature), and shall ensure the claim can be associated with and identified by said source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid

recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.

8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.

9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.

l0. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.

11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.

12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.

13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

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.

SIGNATURES:

The undersigned having read this Agreement for billing Medicaid claims electronically and understanding it in its entirety, hereby agree(s) to all of the stipulations, conditions, and terms stated herein.

Provider Business Name: _____
(Must match name on remittance advice)

Site Address: _____
_____

Office Contact Person: _____ **Phone No.** ( ) _____
Fax No. ( ) _____

Mailing Address: _____
_____

_____
Signature of Authorized Agent **Date**

_____
Typed or Printed Name and Title of Authorized Agent

Provider Number: _____

List of Individual Provider Names, Numbers and Signature, if Billing as a Group: (Complete for practices who will submit claims using a group provider number even if there is only one provider in the group, e.g., physicians, clinics, dentists, practitioners, etc.)

Typed Name of Provider	Attending Number	Signature

DMA APPROVAL:

Accepted effective _____ by _____

NORTH CAROLINA 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.

Group or attending provider number to which this certification applies:_____

(Leave blank if submitting with new enrollment packet. A provider number will be assigned once enrollment is complete. This certification is only applicable to the provider number listed above. When the attending number is required on a claim form, each attending provider is required to fill out a separate certification in addition to the group certification.)

_____
Provider Name (must exactly match name on application)

_____
Signature of Provider Listed Above or Authorized Agent Date
(Authorized Agent only applicable for group provider numbers)

Mail completed form to:
(Must be original, faxes not accepted)

DMA-Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules regarding partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules regarding partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.