Menu Item # 4 – Update Provider Information

The provider application is a required form that is needed for all providers who request entry into SMC's provider network. This form will be need to be reviewed and updated regularly for all providers who wish to continue to participate in SMC's provider network each fiscal year. Updates to agency information can be easily accessed and entered using this screen. To complete your provider application you will access your ***Provider Access Menu 855*** and click on Menu Item # 4 - ***Update Provider Information.***

PROVIDER ACCESS 855

1. Staff Functions Menu
2. STR Menu
3. Services by Location Details
4. Update Provider Information
5. Service Authorization Menu
6. Staff Search List for Provider
7. Claims Menu 863
8. Integrated Service Notes Display
9. Inpatient Tracking Display
10. Document Import and Viewing
11. Admissions and Discharges
12. Financial Information
13. Slot Management
14. Assessments Menu
15. Provider Security Officer Menu
16. Management Reporting Menu

Provider ID: 99008 Name: xxxxx

Contract Manager: Provider Relations Contract Manager Name

Quality Management Specialist: QM Specialist Name

Contract Type: MOA MEMORANDUM OF AGREEMENT Lapse Date: 01/01/2013 Termination Date:

Contract Type: CSDC COMMUNITY SERVICES DIRECT CLIN Lapse Date: 06/30/2010 Termination Date:

Completeness Review Date: 05/27/2009

Credential Committee Review Date: 06/02/2009

Approved? YES

Decision Notification Date: 07/13/2009

Effective Date 07/01/2008 Lapse Date 06/30/2010

Type of Provider: NP NETWORK PROVIDER

Status: AP Active Provider

Any information in the Application that is in "RED" cannot be changed; this information is display only and is updated by your assigned contract manager in the Provider Relations Department. To update this information notify the Provider Relations Department in writing and mail to the address below:

Smoky Mountain Center
Attn: Provider Relations Department
44 Bonnie Lane
Sylva, NC 28779

All other fields will need to be completed in this application.

1. Do you have any DHSR licensed facilities in one of SMC's 15 counties? ☐ YES ☐ NO
Please enter all DHSR numbers below.

2. Do you have any Unlicensed Alternative Family Living facilities? ☐ YES ☐ NO

3. Individual or Agency: ☐ Individual ☐ Agency

4. Web Site Address for North Carolina Consumers:(Leave Blank if you do not have one!)
www.xx.com WEBSITE

5. Normal Hours of Operation: 8-5

6. Corporate Office Physical Address: 14 Love ST Address LINE2: SUITE 300

City: MORGANTON State: NC Zip: 28655 ? NC Burke County: 012 ? BURKE

7. Corporate Office Mailing Address: PO BOX 1536 Address LINE2:

City: MORGANTON State: NC Zip: 28680 ? NC Burke County: 012 ? BURKE

8. Payment Address: Payment billing address can only be entered the first time.

PO Box 1536 Address LINE2:

City: Morganton State: NC Zip: 28680 ? NC Burke County: 012 ? BURKE

9. Corporate Office Phone: 828-437-3000 Corporate Office Fax: 828-437-4999

10. Primary Contact Person's First and Last Names: Mrs. Nice Primary Contact Email: mrsnice @nice.com

11. Agency Contract Signatory: Melaina Rhoney Email: mrhoney@caringalternative.com

12. Contract Signatory Phone: 828-437-3000 Contract Signatory Fax: 828-437-4999

13. Billing/Claims Submissions Contact: Mr. Nice Telephone Number: 828-400-0000 Fax: 828-400-0000

14. Agency Referral Contact: Mrs. Nice Telephone Number: 828 - 400-0000 x 20

15. Email address for slot notifications: mrsnice @nice.com Clinical Home Provider

16. Disaster Response Coordinator:

First Name: Ntalie

Last Name: Nice

After Hours Phone Number:

17. Agency Email:

18. Authorization Email:

19. Endorsed to provide Enhanced Benefit Services? ☒ YES ☐ NO

20. Please provide the name of the LME that conducted your agency's business verification:

MHP

Please send a copy of your NEA letter for each enhanced service you wish to provide in SMC's catchment area to SMC's Provider Relations Department at 44 Bonnie Lane, Sylva, NC, 28779

If newly endorsed by SMC, your NEA letter will be forwarded to your Contract Manager and mailed to you along with your contract.

21. Nationally Accredited? ☒ YES ☐ NO

Through which agency: ☑ CARF ☐ COA ☐ JCAHO ☐ NAEYC ☐ CQLSPD ☐ OTHER

Expiration Date: 12/20/2011 ?

Please include a copy of any one of the following; Letter of Accreditation, a copy of your Intent to Survey document or a formal letter from the agency Executive attesting to the intent to become Accredited.

This Provider's information was last updated by: xxxxxx 12/04/2009 at 2:17pm

22. TriCare Provider? N ?

23. Copies of All required Certificates of Insurance will be provided to SMC? ☐ YES ☐ NO ☐ N/A Medicaid Billable

24. W-9 has been provided: ☒ YES ☐ NO

25. False Claims Letter of Attestation Signed: ☒ YES ☐ NO

26. Federal Tax ID Number or SSN if Individual: 20-4357268 Tax Year End:

27. Group NPI Number: 130000000

28. Is Agency: ☐ Non-Profit ☒ For-Profit

29. This provider intends to serve the following disabilities:

Adult Mental Health ☒ Yes ☐ No

Child Mental Health ☒ Yes ☐ No

Adult Substance Abuse ☐ Yes ☒ No

Child Substance Abuse ☐ Yes ☒ No

Adult Developmental Disabilities ☒ Yes ☐ No

Child Developmental Disabilities ☒ Yes ☐ No

30. This provider intends to serve the following North Carolina SMC area counties:

Alexander ☒ Yes ☐ No

Alleghany ☐ Yes ☒ No

Ashe ☐ Yes ☒ No

Avery ☐ Yes ☒ No

Caldwell ☒ Yes ☐ No

Cherokee ☐ Yes ☐ No

Clay ☐ Yes ☐ No

Graham ☐ Yes ☐ No

Haywood ☐ Yes ☐ No

Jackson ☐ Yes ☐ No

McDowell ☐ Yes ☐ No

Macon ☐ Yes ☐ No

Swain ☐ Yes ☐ No

Watauga ☐ Yes ☐ No

Wilkes ☐ Yes ☐ No

Are you currently accepting referrals? ☐ Yes ☐ No

These buttons take you to additional screens where more information about your agency locations and staff can be updated:

Provider Service by Location Data	Staff Search Update Credentials

Question 31- These are a series of questions relative to Medicaid fraud and must be answered yes or no. If you answer yes to any question please provide a detailed explanation in the box displayed.

I attest that all services I intend to deliver will be in accordance with any applicable best practice standards and service definitions.

Open Staff Information Screen –(Opens another information screen)

I attest that for all services provided, this organization will adhere to all applicable best practice standards and service definitions.

☐ Yes ☐ No

I attest that the above information is current, accurate, and truthful. I affirm that I have ready carefully and understand the items set forth in this Application. I further affirm that my statements (including any attachments) are true and complete to the best of my knowledge and freely given. I attest by my signature that I understand that any mistatement of material fact submitted by me may be sufficient cause to render this application invalid and disbar this agency from further network participation, and could result in other appropriate action.

xxxxx 12/04/2009 2:17pm

I Agree.

I Do Not Agree.

Save it and I'll agree later.

Script PROVIDERS By Rick Shoestock 3/09

If you are a new provider, save the application and it will be emailed to your contract manager to review along with other documentation to complete your contract packet.