



NC*Notify Enrollment Form

Please complete this form if you are initially enrolling in NC*Notify or if you need to change your enrollment information.

All fields must be complete to process your enrollment.

Organization Information

Organization Name	
Organization Address	
Organization Phone Number	
Organization Type	<input type="checkbox"/> Hospital <input type="checkbox"/> Primary Care <input type="checkbox"/> Free Clinic <input type="checkbox"/> Community Health Center/FQHC <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Specialist <input type="checkbox"/> Other
Organization NPI	
Medicaid Region	<input type="checkbox"/> Region 1 <input type="checkbox"/> Region 2 <input type="checkbox"/> Region 3 <input type="checkbox"/> Region 4 <input type="checkbox"/> Region 5 <input type="checkbox"/> Region 6 <input type="checkbox"/> All Regions

Contact Information

Contact Type	Contact Name	Contact Phone	Contact E-mail
Organization – <i>Your Primary Contact will receive notifications from NC HIEA regarding system updates and outages; usually the Participant Account Administrator; could also be Population Health Coordinator.</i>			
Technical Administrator – <i>Your contact for project implementation, ongoing support, etc.</i>			

Mobile Contact Information – **For future delivery via text, please provide.*

*Mobile Phone	*Mobile Carrier

Patient Panel *(This is the list of patients that you would like monitored.)*

Panel update frequency	<input type="checkbox"/> Auto-Attribution <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
Number of patients anticipated in each panel _____	Number of unique providers _____
Patient panels should be submitted to NC*Notify via:	<input type="checkbox"/> Secure File Transfer Protocol (sFTP) <input type="checkbox"/> Direct Secure Message (DSM) <input type="checkbox"/> NC HealthConnex Clinical Portal Self-Service Patient Panel Loader <input type="checkbox"/> Auto-Attribution

Notifications Delivery *(This is the method of how you would like to receive alerts on the patients you have chosen to monitor.)*

Patient event notifications should be delivered:	<input type="checkbox"/> Near Real-Time <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> HL7 <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
Patient event notifications should be delivered via:	<input type="checkbox"/> Near Real-Time Alerts via NC*Notify Dashboard <input type="checkbox"/> Flat File via sFTP <input type="checkbox"/> Flat File via DSM <input type="checkbox"/> Near Real-Time Alerts via HL7 (*HL7 alerts will require TLS and/or sFTP. Our technical team will send you a connection form to initiate this process.)

Do you have NC HealthConnex clinical portal credentials? *(*You'll need credentials to access the NC*Notify dashboard.)*

☐ Yes ☐ No

Connectivity Request – Complete this section only if you plan to utilize sFTP or DSM for submission and retrieval of notifications. Note: You do not need to complete this section if you elected auto-attribution, self-service panel loader, or the NC*Notify dashboard above.

Table 1: For sFTP users

sFTP Technical Details	
Sending Static IP Address (External IP Address of Server connecting to SAS FTP Server) If you are unsure, please use this link to verify: https://www.whatismyip.com/ip-address-lookup/	
IP Address Provider	
CIDR Block	

**If you are unsure whether you have a CIDR Block, please leave blank.*

Table 2: For Direct Secure Message users

Do you already have a DSM Address?
<input type="checkbox"/> Yes, Our DSM address is:
<input type="checkbox"/> No, please create a new DSM address (no cost).

Third Party Organization Information

If a third-party organization, like an Accountable Care Organization or a Clinically Integrated Network, will be providing the patient panel and receiving the alerts on your behalf, please list that organization's information here. Please note: To ensure both parties are HIPAA compliant, confirm there is a Business Associate Agreement in place between you and the third-party organization.
Third Party Organization Name:
Contact Name:
Contact Email:
Contact Phone:

Will this third-party organization be submitting your patient panels?

☐ Yes ☐ No

Will this third-party organization also be receiving your notifications?

☐ Yes ☐ No

NC*Notify Enhanced Alerts

Below is a list of our most recent service offerings. Please review each of the upgraded alerts and select all alerts your facility would like to receive. The NC*Notify team will work to add your selections to your connection.

- ☐ **COVID Lab Alerts** - These alerts will notify providers when a patient's COVID-19 laboratory results are available. *Current NC*Notify dashboard users will automatically receive COVID lab alerts.

☐ **High Utilizer Indicators** - This upgrade will help providers identify frequent flyers to the Emergency Department (ED) (Two or more visits in 90 days or less) or patients that are at a high risk for readmission (Four or more admissions in 12 months).

☐ **Dental Alerts** - Providers will be alerted when patients utilize the emergency department for dental care.

☐ **Care Team Change Alerts** - *Providers will be informed when a new organization has subscribed to their patient.*

*Only available to NC*Notify dashboard users.

☐ **Newly Diagnosed Diabetic & Pre-Diabetic Patient Alert** - *Providers will be alerted upon a new diabetes and/or pre-diabetes diagnosis.*

☐ **Patients Eligible for CMS Chronic Care Management (CCM)** - *Providers will receive an alert when a patient meets the Centers for Medicare and Medicaid Services (CMS) Chronic Care Management (CCM) services criteria.*

Substance Use Disorder Treatment Facilities

For practices or facilities that provide substance use disorder treatment services, we require confirmation of whether your organization is covered by 42 CFR Part 2 ("Part 2 Program"). These providers may still receive access to the NC HealthConnex clinical portal; however, **we cannot provide NC*Notify to organizations that only provide substance use disorder services and that are covered by 42 CFR Part 2.** If only one or a few providers or units within a general medical facility are considered Part 2 Programs, then the main facility can still participate in NC*Notify.

Please check one box below: **Required**

☐ This organization does not provide substance use disorder treatment services and/or is not covered by 42 CFR Part 2.

☐ Only one or more providers or units within the general medical facility are Part 2 Programs.

☐ My entire organization is considered a Part 2 Program.

Time Period

If your facility/organization is not using auto attribution, at a minimum, quarterly updates of the patient panel must be provided to NC HealthConnex for this service to ensure active patient relationships.

Justification of Patient List

Participants enrolled in the NC*Notify service must use their judgment, based on their clinical background or other health care expertise, to provide NC HealthConnex with a patient list that only includes information related to patients for whom they can reasonably expect that most encounters will be relevant to their care and/or care coordination of that patient. For example, an Obstetric provider may choose to receive notifications only for patients that are currently expectant or within a defined postpartum period, but not for all other patients.

Attestation

By signing this form, I attest that:

- ✓ My organization has executed a full NC HIEA Participation Agreement from 2017, 2018, or 2021;
- ✓ I and/or the third party listed in this form will utilize the patient data received from NC*Notify for the Permitted Purposes defined in the NC HIEA Participation Agreement, any other third-party agreements that must include a Business Associate Agreement, and pursuant to HIPAA and applicable law;
- ✓ I or the third party listed in this form will only request patient data for those patients for whom organization is responsible; and
- ✓ I will indemnify and hold the NC HIEA harmless for properly disclosing notifications to my organization and/or the third party listed in this enrollment form.

Participant Representative:

NC HIEA Representative:

Signature: _____ Signature: _____

Name/Title: _____ Name/Title: _____

Date: _____ Date: _____