NC Notify
Event Notifications Powered by NC HealthConnex

V3 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	☐ LME/MCO ☐ Health Plan/Payer
Medicaid Region	☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5 ☐Region 6

Contact Information

Contact Type	Contact Name	Contact Phone	Contact E-mail
Organization – 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*			
Technical Administrator - Your contact for project implementation, ongoing support, etc.			

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

*Mobile Phone	*Mobile Carrier

Member Panel

Panel update frequency	☐Weekly ☐Monthly ☐Quarterly
Number of members anticipated in each panel _____	

Notifications Delivery

Delivery Frequency	☐ Near Real Time ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

Technical Information

How would you like to send member panels?

Direct Secure Message (DSM) ☐ Secure File Transfer Protocol (sFTP) ☐

How would you like to receive member alerts?

Same method as above ☐ Near Real Time Alerts ☐ Flat File ☐

**Near Real Time Alerts will require a VPN Connection. Our technical teams will send you a VPN Connection form to initiate this process.

(If using DSM, proceed to table 4.)

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	
CIDR Block	

Table 4: For Direct Secure Message users

Do you already have a DSM Address?
☐ Yes, Our DSM address is:
☐ No, please create a new DSM address (no cost).

3rd 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, please make sure 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:

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

At a minimum, quarterly updates of the member panel must be provided to NC HealthConnex for this service to ensure active care relationships.

Justification of Patient List

Participants enrolled in the NC*Notify service must use their judgment, based on their health care expertise, to provide NC HealthConnex with a member list that only includes information related to members for whom they can reasonably expect that the majority of encounters will be relevant to their care and/or care coordination of that patient.

Attestation

By signing this form, I attest that:

- ✓ My organization will not reroute or disclose NC*Notify alerts to Health Care Providers who are not Workforce members of Participant's organization, including third party NC HealthConnex Participants. Additionally, participant shall not use NC*Notify feature to deny claims or to rate Participant's member.
- ✓ My organization has executed a full NC HIEA Participation Agreement from 2019 or 2020

- ✓ 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 members for whom organization is responsible; and
- ✓ I will indemnify and hold NC HIEA harmless for properly disclosing notifications to my organization and/or the third party listed in this enrollment form.

Participant Representative:

Signature: _____

Name/Title:_____

Date: _____

NC HIEA Representative:

Signature: _____

Name/Title:_____

Date: _____

After completing this form, please scan/email a signed copy to: hiea@nc.gov. A member of the NC*Notify team will contact you with next steps.