NC*Notify Enrollment Form for Payers (V5)

All fields must be complete to process your enrollment.

Organization Information

Organization Name	
Organization Address	
Organization Phone	
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 & Title	Contact Phone	Contact E-mail
NC*Notify Primary Contact – *The Primary Contact will receive notifications from the NC HIEA regarding system updates and outages.*			
Technical Administrator - *The technical administrator will be the contact for project implementation and ongoing support.*			

Member Panel: Frequency and Size of Patient Panel Submission and Updates

(Panels should be submitted at least once every 90 days.)

Please choose from the following options how frequently panels will be updated. At a minimum, quarterly updates of the member panel must be provided to NC HealthConnex for this service to ensure active care relationships.	☐ Weekly ☐ Monthly ☐ Quarterly
Number of members anticipated in each panel:	

Notifications Delivery

Please choose from the following options how frequently you would like to receive patient event notifications:	☐ 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 require a TLS Connection. The NC HIEA technical team will send a TLS Connection form to the technical administrator to initiate this process.**

(If using DSM, proceed to Table 2)

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?
☐ Yes, Our DSM address is:
☐ No, please create a new DSM address (at 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, 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

Justification of Patient List

Participants enrolled in the NC*Notify service (or a Participant's designated third-party specified above) must use their judgement, 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 on behalf of _____ ("Enrolling Organization") 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;
- ✓ 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;
- ✓ My organization is not an entity that is entirely covered by 42 CFR Part 2 ("Part 2 Program"); and
- ✓ My organization will not include patient information (including name) that is protected by 42 CFR Part 2 in the patient panel.

Participant Representative:	NC HIEA Representative:
Signature: _____	Signature: _____
Name/Title:_____	Name/Title:_____
Date: _____	Date: _____