



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	<input type="checkbox"/> LME/MCO <input type="checkbox"/> Health Plan/Payer
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

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	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
Number of members anticipated in each panel _____	

Notifications Delivery

Delivery Frequency	<input type="checkbox"/> Near Real Time	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Monthly	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes, Our DSM address is:
<input type="checkbox"/> 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:

NC HIEA Representative:

Signature: _____

Signature: _____

Name/Title: _____

Name/Title: _____

Date: _____

Date: _____