North Carolina Medicaid
Temporary Enrollment Application

Provider Name: ____________________

Provider Type / Specialty: ____________________

Type of Entity (Select only one. Must match entity on W9):

- ☐ Individual/sole proprietor
- ☐ C Corporation
- ☐ S Corporation
- ☐ Partnership
- ☐ Limited liability company (Enter the tax classification [C=C corporation, S=S corporation, P=partnership]):
- ☐ Trust/estate

Are you a private or public person/entity? ☐ Private ☐ Public

Physical Address: ____________________

Accounting Address: ____________________

Phone Number: ____________________

Email Address: ____________________

Legal Name According to the Internal Revenue Service (IRS): ____________________

Tax I.D. No. (if applicable): ____________________

Social Security Number: ____________________ **Date of Birth:** ____________________

Gender: ☐ Male ☐ Female

NPI : ____________________ **Taxonomy Code:** ____________________

License No. and State Issuer: ____________________

Are you using a Medicare certification number for this enrollment?

☐ Yes ☐ No

If yes, provide your Medicare certification number: ____________________

Are you enrolled in other State's Medicaid program?

☐ Yes ☐ No

If yes, please provide the name of the State, and any ID number if applicable: ____________________

Do you have the legal right to work in the United States? ☐ Yes ☐ No

Have you ever been convicted of a crime (excluding minor traffic citations)? ☐ Yes ☐ No

If yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of:

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IMPORTANT: *The following section is only applicable for providers that are* **not** *an individual or are not already enrolled in Medicare or another State's Medicaid program. If you are enrolled in Medicare or another State's Medicaid program, continue to page 3 to sign this application.*

Owners, Partners, Officers, Directors, and Principals

Identify persons who are sole proprietors or owners, partners, officers, directors, and principals. If you have multiple individuals to disclose, provide the information requested below for all applicable parties.

A Principal of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

The following questions are applicable to each person, as defined above:

First and Last Name: ______________________________

Social Security Number: ______________________ **Date of Birth:** ______________

Gender: ☐ Male ☐ Female

Do you have the legal right to work in the United States? ☐ Yes ☐ No
Have you ever been convicted of a crime (excluding minor traffic citations)? ☐ Yes ☐ No

If yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of:

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Disclosure of Ownership

(*Not applicable for providers enrolled in Medicare or another SMA's Medicaid program*)

Identify the entities with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number:

Name: ______________________________

Address: ______________________________

Federal Tax ID: ______________________________

Disclosure of Relationship

(*Not applicable for providers enrolled in Medicare or another SMA's Medicaid program)*

Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):

Provider/Principal 1: ______________________________

Has a Relationship as: ______________________________

to Provider/Principal Name 2: ______________________________

Agreement

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. This Short Form Application process is valid through January 1, 2018.

Signature: ______________________________ **Date:** ______________________________

Submit Application