We would like to thank you for your interest in enrolling as a Licensed Independent Practitioner ("LIP") in the Cardinal Innovations Healthcare ("Cardinal Innovations") provider network. Enrollment requires that you be credentialed and either contracted with Cardinal Innovations or employed by a contracted provider.

The state of North Carolina maintains a claims system named NCTracks and requires Cardinal Innovations to submit claims data through the NCTracks system. In order that claims data submitted to Cardinal Innovations is ultimately accepted by the NCTracks system, all clinicians seeking to be credentialed by Cardinal Innovations must be enrolled in the NCTracks system and must additionally be affiliated in NCTracks to the contracted provider who intends to submit claims for the clinician's services. Cardinal Innovations will only accept credentialing applications from practitioners that are already enrolled at NCTracks and affiliated with their provider agency or who have begun the process of enrolling and affiliating with NCTracks by submitting an application or a Managed Change Request (MCR).

If an application is submitted for a practitioner who is not enrolled or affiliated in NCTracks, the application must include the NCTracks enrollment application prepared for the clinician to submit. If the clinician is enrolled but not affiliated with your agency, a copy of the MCR submitted to NCTracks requesting affiliation will be required. Applications from practitioners who are not enrolled and/or affiliated that do not include either the Enrollment Application or MCR could be returned if these requirements are not satisfied in a reasonable amount of time.

To enroll and affiliate, please go to www.nctracks.nc.gov. From there, click on the providers tab and select "Provider Enrollment" from the menu on the left.

All NCTracks application documents must be printed or saved prior to submission. To print or save the documents, please select the option to review when you have reached the end of the application. While you are reviewing the document, please either print the document or print the document to a PDF which you can save. Failing to review and print the application prior to submitting will result in an inability to save a copy of the forms until after it has been approved at a much later date. This will delay your credentialing until your NCTracks is complete. Please send a copy of all NCTracks forms with your Credentialing Registration Form to Network Management at NetworkMGT@cardinalinnovations.org.

To initiate LIP credentialing: print out, complete and submit the attached Credentialing Registration Form, and have the two reference forms completed. You can send the scanned documents as an email attachment to NetworkMgt@cardinalinnovations.org, fax it to the **Credentialing Department** at 704-939-7513, or mail it to Cardinal Innovations Healthcare, Network Management Department, 550 South Caldwell Street, Suite 1500; Charlotte, NC 28202. We will confirm receipt of the documents by email. Once we do so, we will share pertinent information provided in the Credentialing Registration Form with the Council for Affordable Quality Healthcare ("CAQH")*. CAQH will contact you directly with instructions for completing their online application. You will be given the opportunity to designate Cardinal Innovations as an authorized entity able to view your information in the CAQH system.

*The Council for Affordable Quality Healthcare ("CAQH") provides a streamlined, secure method for electronic data collection – *at no cost to you*. Providers keep total control of the data, authorizing access only to the participating managed care organizations of their choice. Revisions made by you are available instantly to authorized organizations. Additional information can be found at: https://proview.caqh.org/Login/Index?ReturnUrl=%2fpo

In addition, please note the following important information regarding the attestation statement on our website at the following link: http://www.cardinalinnovations.org/docs/attestation-statement.pdf.

Please upload the attestation statement with your CAQH application. It must be signed and dated as of the date of your CAQH application upload. If the date predates the application upload, it will not be valid. This is important because the credentialing process cannot begin without a valid attestation statement relating to the CAQH application identified with Cardinal Innovations Healthcare.

For your convenience, below is a summary of the process that will take place following receipt of the completed Credentialing Registration Form, reference forms, and the completion of the CAQH on-line application:

- Cardinal Innovations will complete the required background checks and verify information supplied in the Credentialing Registration Form and CAQH application. **This process will not begin until there is a complete CAQH application**, which includes all supporting documentation and the properly dated Attestation Statement available to Cardinal Innovations in the CAQH system.
- Once the verification process is complete, your file will be submitted to the Cardinal Innovations Medical Director for review. If there are no questions or concerns, the Medical Director will approve the file and you will be credentialed by Cardinal Innovations. If there are questions or concerns, the file will be submitted to the Cardinal Innovations Credentialing Committee for review. You will be contacted at this time for any additional information or explanation required for the Credentialing Committee review. You will be notified of the committee's decision within thirty (30) days.
- If you are credentialed and a contract is required for your network participation; the contract will be processed by a Cardinal Innovations Contract Coordinator. If necessary, the Contract Coordinator may request additional information for the contracting process.
- Once the contract is signed by all relevant parties, you will be notified of your enrollment status and may begin rendering services to Cardinal Innovations members.

As part of the Cardinal Innovations credentialing process, each clinician has the right:

- To review information collected during the credentialing process except the references and
- National Practitioner Data Bank (NPDB), upon request
- To be informed of the status of their credentialing application, upon request
- To be notified of information that is significantly different than reported by you and to have the opportunity to correct erroneous information in writing
- To be notified about the Credentialing Committee's decision within thirty (30) days of the committee's decision or Medical Director's approval

Thank you for your interest in Cardinal Innovations Healthcare. If you have any questions, please contact Network Management Customer Service at 800-958-5596.

Credentialing Registration Form

Please note this is a Credentialing Registration Form only. Upon receipt of this form, Cardinal Innovations will send you instructions regarding completing the Credentialing Application. The credentialing process will begin upon completion of the Credentialing Application. Please be sure to sign the completed application on the signature line located on page 5.

Clinician Name _____
First Middle (No Initial) Last Maiden

Name of Agency/Practice _____

☐ Yes ☐ No Is Agency/Practice Contracted with Cardinal Innovations?

If No, which service need are you applying to meet from the Service Needs list:

_____

The Service Needs list can be found on the Cardinal Innovations website under the "Resource Library."

Clinician License Type* _____

* e.g., MD, DO, Neuropsychologist, LPC, Clinical Psychologist, LCSW (A), LMFT(A), PA, LCAS (A)

Agency/Practice Address _____
Street City State ZIP

Mailing Address _____
For CAQH correspondence Street or P.O. Box City State ZIP

Email Address _____

Phone Number _____ 24 hour/7 day Coverage Phone Number _____

Additional Information Needed

CAQH ID Number _____ Clinician NPI Number _____

Clinician Taxonomy Code _____

Date of Birth _____ Social Security Number _____
Month (MM) Day (DD) Year (YYYY)

Language(s) other than English in which you are able to communicate fluently

☐ Spanish ☐ Other (specify) ☐ Available Interpreter Types (specify)

☐ American Sign Language _____ _____

Gender and Race/Ethnic Background: (Information is voluntary and can be used publicly.)

☐ Male ☐ Caucasian ☐ Black/African American ☐ American Indian/Alaskan Native American

☐ Female ☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Multi-racial

Provisional/Associate Licensed Practitioners and BCBAs

Provide a copy of your current supervision contract and the name/contact information of your clinical supervisor.

Clinical Supervisor _____

Address _____
Street City State ZIP

Phone _____ Email _____

References

Have submitted a minimum of two **Provider Evaluation Forms**.
At least one of the forms must come from a like-licensed practitioner.

Note: *If provisionally/associate licensed, one of the evaluations must come from your clinical supervisor.*

Employment Gaps (Explain any gaps longer than six (6) months)

_____

_____

_____

_____

_____

Professional Liability Insurance

☐ Yes ☐ No Amount of $1 million/$3 million?

NCTracks Information

All NCTracks application documents must be printed or saved prior to submission. To print or save the documents, please select the option to review when you have reached the end of the application. While you are reviewing the document, please either print the document or print the document to a PDF which you can save. Failing to review and print the application prior to submitting will result in an inability to save a copy of the forms until after it has been approved at a much later date. This will delay your credentialing until your NCTracks is complete.

Please send a copy of all NCTracks forms with your Credentialing Registration Form. *We will not move forward with an application that does not have all required NCTracks forms. We cannot accept any other forms of documentation besides the Provider Enrollment application or Managed Change Request. We are unable to make exceptions to this rule.*

☐ Yes ☐ No Has the clinician named above had their NCTracks Provider Enrollment application completed and approved by NCTracks?

You will know this step is complete if you are able to log in to NCTracks.

If Yes: Please make sure the clinician is also affiliated to the specific address that is listed on page 1.

If No: Please make sure to submit the Provider Enrollment application with this registration form and make sure the affiliation section is completed to the specific address that is listed on page 1.

If the clinician has not begun the enrollment process, please do so immediately, being sure to affiliate with the agency/practice listed on the first page of the credentialing registration form and ***be sure to save a copy of the enrollment application.***

If the clinician has completed and been approved in NCTracks, but has not been affiliated with the agency/practice listed on the first page of the credentialing registration, please submit a Managed Change Request immediately and ***be sure to save a copy.*** *Please send a copy of the Managed Change Request with this application*

To save a copy of your NCTracks enrollment application, select the option to "review" the document at the end before pressing "submit" and then print or print to PDF. Please send the PDF enrollment application or MCR with this registration form.

Provider Specialty Practice Information

Help us communicate to member, staff, and others what they need to know about your practice. Credentialing and contracting for an LIP or LIP Group cannot be initiated without receipt of this form. Check below that all that apply to your scope of practice/expertise.

Taxonomy Code(s) associated with Practice _____

Target Population

☐ MH-Adult ☐ SA-Adult ☐ IDD-Adult
☐ MH-Child ☐ SA-Child ☐ IDD-Child

Hours of Operation:

Days of Operation:

General Categories

☐ Mental Health
☐ Intellectual/Developmental Disabilities
☐ Substance Use Disorder

Ages

☐ Young Child (3-5)
☐ Older Child (6-12)
☐ Adolescent (13-20)
☐ Adult (21-64)
☐ Geriatrics (65+)

Specialty and Applied Approaches

☐ Autism Spectrum
☐ Dialectical Behavioral Therapy
☐ Traumatic Brain Injury
☐ ADHD
☐ Mood Disorders
☐ Sex Offender Treatment
☐ Neurodegenerative Disorders
☐ Conduct Disorders
☐ Neuropsychological Disorders
☐ Personality Disorders
☐ Sexual Behavior Problems:
  ☐ Adult ☐ Youth
  ☐ Certified in Risk Assessment for Sexual Harm
☐ Alcohol and other Drug Abuse
☐ Co-occurring MH/SUD Issues
☐ Gay/Lesbian/Transgender
☐ Anxiety Disorders
☐ Anger Management
☐ Cognitive Behavior Therapy
☐ Group Therapy
☐ Applied Behavioral Analysis
☐ HIV/AIDS
☐ Psychotic Disorders
☐ Faith-Based Counseling
☐ Psychological Testing
☐ Behavior Therapy
☐ Biofeedback
☐ Forensic Screening/Evaluation (NC State Certified)
☐ Trauma Focused Treatment
☐ Family Systems
☐ Post-Traumatic Stress Disorder
☐ Learning Disabilities
☐ Dementia
☐ Play Therapy
☐ Women's Issues
☐ Parent Training
☐ Eating Disorders
☐ Other (specify)

Clinician Certification/Expertise (may require verification)

☐ Addiction Psychiatry Fellowship, Board or ASAM Certification
☐ Addiction Treatment (LCAS, CSAC, CCS)
☐ Child Psychiatry Fellowship, or Board Certification
☐ Forensic Psychology/Psychiatry

Culturally diverse populations that you feel competent to treat

☐ Caucasian
☐ Black/African American
☐ American Indian/Alaskan Native American
☐ Asian/Pacific Islander
☐ Hispanic/Latino
☐ Other (specify)

Counties Served

Community Office	County				
Alamance/Caswell	☐ Alamance	☐ Caswell			
Five County	☐ Franklin	☐ Granville	☐ Halifax	☐ Vance	☐ Warren
OPC	☐ Orange	☐ Person	☐ Chatham		
Piedmont	☐ Cabarrus	☐ Davidson	☐ Rowan	☐ Stanly	☐ Union
Mecklenburg	☐ Mecklenburg				
Triad	☐ Davie	☐ Forsyth	☐ Rockingham	☐ Stokes	

Accessibility

☐ Yes ☐ No Handicapped accessible?

Specialty Privileges

Are you applying for any of the following specialty privileges?

☐ Trauma Focused Cognitive Behavioral Therapy (TF-CBT) or PCIT*

☐ Sexual harm assessment services for children and adolescent*

☐ Applied Behavior Analysis (ABA) Services for Autism Spectrum Disorder (ASD)

** If applying for one of these services, please also fill out and submit the application for that specific privilege. The applications can be found on our website within the resource library. You may search for the individual applications by searching for them in the search box above the resource type filter on the left side of the page.*

Signature: _____ Date: _____

Of the practitioner for whom the application is being submitted

Please sign and date your completed application. Unsigned applications will not be accepted.

Cardinal Innovations Healthcare Provider Evaluation Form

☐ Peer (Licensed Practitioner, not partner) ☐ Referring Physician or Practitioner ☐ Supervisor
☐ Chief of Department/Staff where practitioner has admitting privileges (Not partner)

Name of Applicant _____ Group Name _____

The above provider is a Cardinal Innovations Healthcare network applicant. Please provide us with information concerning his/her professional qualifications. *All information submitted* will be held in strict confidence.

1. What is your specialty/credentials? _____
2. What is your relationship to the applicant? _____
3. How long have you known the applicant? _____
4. How would you rate the applicant's professional abilities?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
5. How would you rate the applicant's ability to work and communicate with physician and non-physician staff?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6. How would you rate the applicant's rapport with consumers/clients?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
7. What do you believe to be the applicant's strengths and weaknesses (if any)?
   a) Strengths: _____
   _____
   b) Weaknesses: _____
   _____
8. To your knowledge, has the applicant had any of the following:
   ☐ Yes ☐ No Malpractice claim(s)?
   ☐ Yes ☐ No Problems with medical licensure, certification, or licensing boards?
   ☐ Yes ☐ No Revocation, denial, or change in hospital privileges?
   ☐ Yes ☐ No History of/or current impairment due to drugs and/or alcohol?

   If your answer is yes to any of the above questions, please provide details.

   _____
9. Would you recommend this person as a provider for the Cardinal Innovations Healthcare network?
   ☐ Without reservation ☐ With reservation ☐ Would not recommend
10. Please provide any other information that would be helpful to us in evaluating this applicant.

    _____
    _____

Evaluator's Signature _____ Date _____
Printed Name _____ Phone _____
Complete Address _____

Cardinal Innovations Healthcare Provider Evaluation Form

☐ Peer (Licensed Practitioner, not partner) ☐ Referring Physician or Practitioner ☐ Supervisor
☐ Chief of Department/Staff where practitioner has admitting privileges (Not partner)

Name of Applicant _____ Group Name _____

The above provider is a Cardinal Innovations Healthcare network applicant. Please provide us with information concerning his/her professional qualifications. *All information submitted* will be held in strict confidence.

1. What is your specialty/credentials? _____
2. What is your relationship to the applicant? _____
3. How long have you known the applicant? _____
4. How would you rate the applicant's professional abilities?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
5. How would you rate the applicant's ability to work and communicate with physician and non-physician staff?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6. How would you rate the applicant's rapport with consumers/clients?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
7. What do you believe to be the applicant's strengths and weaknesses (if any)?
   a) Strengths: _____
   _____
   b) Weaknesses: _____
   _____
8. To your knowledge, has the applicant had any of the following:
   ☐ Yes ☐ No Malpractice claim(s)?
   ☐ Yes ☐ No Problems with medical licensure, certification, or licensing boards?
   ☐ Yes ☐ No Revocation, denial, or change in hospital privileges?
   ☐ Yes ☐ No History of/or current impairment due to drugs and/or alcohol?

   If your answer is yes to any of the above questions, please provide details.

   _____
9. Would you recommend this person as a provider for the Cardinal Innovations Healthcare network?
   ☐ Without reservation ☐ With reservation ☐ Would not recommend
10. Please provide any other information that would be helpful to us in evaluating this applicant.

    _____
    _____

Evaluator's Signature _____ Date _____
Printed Name _____ Phone _____
Complete Address _____

Acknowledgement, Consent and Authorization for Required Background Screening

Pursuant to 42 CFR §455.450 and N.C. Gen. Stat. §108C, Cardinal Innovations Healthcare is required to conduct certain background screening of all individual practitioners and all individuals disclosed pursuant to 42 CFR § 455.100-106 as acting on behalf of an organizational agency/practice, applying to be credentialed/enrolled or re-credentialed/re-enrolled as Medicaid providers. Some of these background screenings, for instance a criminal history report obtained from FirstPoint, Inc., P.O. Box 26140 Greensboro, NC 27402, 800.449.0245, www.firstpointresources.com, could possibly be construed as a "consumer report" under the Fair Credit Reporting Act, (FCRA) 15 U.S.C § 1681 et seq.

The undersigned individual practitioner applicant or organizational agency/practice applicant, by the below signature, hereby acknowledges, consents and authorizes Cardinal Innovations Healthcare to obtain the above required background screening information necessary to properly process and assess any credentialing/enrollment or re-credentialing/re-enrollment application as the case may be. This acknowledgement, consent and authorization will be construed as continuing during the entire time of the individual practitioner's or organizational agency/practice's credentialing/enrollment with Cardinal Innovations Healthcare. Additionally, the applicants, by their signature below, hereby release from liability all representatives of Cardinal Innovations Healthcare for acts performed in good faith and without malice in connection with acquiring the above required background screening information and further release from liability all individuals and organizations, including FirstPoint, Inc., P.O. Box 26140 Greensboro, NC 27402, that provide such information to Cardinal Innovations Healthcare in connection with their application.

Please sign, date and legibly print the name of the signatory below.

_____ _____

Individual Practitioner Applicant Signature Date

_____

Printed Name of Individual Practitioner Applicant

_____ _____

Organizational Agency/Practice Applicant Authorized Representative Signature Date

_____

Printed Name and Title of Authorized Representative of Organizational Agency/Practice Applicant