



Comprehensive Provider Application Request Form

This form is used for:

- New providers requesting to join the Alliance Health network
- Out-of-network providers submitting a single case application
- Contracted providers seeking to add new sites or service codes

Please note:

- Alliance is currently accepting network applications for all behavioral health services required under the NC Medicaid Plan, except for services within our closed network. A list of all current behavioral health service needs can be found here: AllianceHealthPlan.org/providers/network/service-needs/. Alliance is also accepting network applications from physical health providers for Tailored Plan members.
- All relevant information must be completed for your request to be processed.

NCTracks verification

If the provider is not enrolled in NCTracks, Alliance will not be able to process this request.

1

Is the provider enrolled in NCTracks?*

☐ Yes ☐ No

Request type

2

What is the nature of this request? (choose one)*

☐ **New provider** requesting to join the Alliance Health network ☐ Provider has reviewed Alliance Health service needs list

☐ **Out-of-network provider** submitting a single case agreement Requested effective date (mm/dd/yyyy) _____

☐ **Contracted provider** seeking to add site(s) and/or service(s)

Provider type

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Behavioral health only provider

☐ Agency ☐ Licensed independent practitioner/solo practice ☐ Licensed independent group practice

Physical health only provider

☐ Physical health practice ☐ Other (please specify): _____

Behavioral health and physical health provider

☐ Agency ☐ Other (please specify): _____

Hospital provider

☐ Behavioral health only ☐ Physical health only ☐ Both behavioral health and physical health

Provider information

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Today's date (mm/dd/yyyy):*

Provider full legal name (as it appears in NCTracks):*

Tax ID:* -

SSN if no Tax ID:* - -

National provider identifier (NPI):*

Provider address line 1* _____ Address line 2* _____
Street, P.O. Box, etc. Suite, Building, etc.

City* _____ State* _____ Postal code* _____

Provider information

Continuation

4

Associated entity type:*

☐

Hospital

☐

Agency

☐

Group

☐

Licensed independent practitioner/solo practice

Is this NPI and address registered in NCTracks?*

☐

Yes

☐

No

Contact information

Please include the contact information for the person submitting the request.

5

Requester name:* _____ Title:* _____

Phone:* _____ Email:* _____

Service site(s)

Please complete this section identifying the site(s) where you will be providing the service(s).

6

Site name:* _____

Address line 1* _____ Address line 2* _____
Street, P.O. Box, etc. Suite, Building, etc.

City* _____ State* _____ Postal code* _____

Site NPI number:*

NCTracks Location Code:*

Please identify the client population(s) served at this site:*

☐

MH adult

☐

SA adult

☐

DD adult

☐

TBI adult

☐

MH child

☐

SA child

☐

DD child

Requested effective date (mm/dd/yyyy):* _____ Site registered in NCTracks* ☐ Yes ☐ No

Site name:* _____

Address line 1* _____ Address line 2* _____
Street, P.O. Box, etc. Suite, Building, etc.

City* _____ State* _____ Postal code* _____

Site NPI number:*

NCTracks Location Code:*

Please identify the client population(s) served at this site:*

☐

MH adult

☐

SA adult

☐

DD adult

☐

TBI adult

☐

MH child

☐

SA child

☐

DD child

Requested effective date (mm/dd/yyyy):* _____ Site registered in NCTracks* ☐ Yes ☐ No

Site name:* _____

Address line 1* _____ Address line 2* _____
Street, P.O. Box, etc. Suite, Building, etc.

City* _____ State* _____ Postal code* _____

Site NPI number:*

NCTracks Location Code:*

Service site(s)

Continuation

📎 If you need to include more than 3 addresses, please attach additional documentation to this application.

6

Please identify the client population(s) served at this site:*

☐ MH adult

☐ SA adult

☐ DD adult

☐ TBI adult

☐ MH child

☐ SA child

☐ DD child

Requested effective date (mm/dd/yyyy):* _____ Site registered in NCTracks* ☐ Yes ☐ No

Service(s) requested

Please complete this section identifying the service(s) you are requesting to provide.

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Requested title of service:* _____

Requested service code:* _____ Is service included on needs list?* ☐ Yes ☐ No

Requested effective date (mm/dd/yyyy): _____

Requested title of service:* _____

Requested service code:* _____ Is service included on needs list?* ☐ Yes ☐ No

Requested effective date (mm/dd/yyyy): _____

Requested title of service:* _____

Requested service code:* _____ Is service included on needs list?* ☐ Yes ☐ No

Requested effective date (mm/dd/yyyy): _____

📎 If you need to include more than 3 services, please attach additional documentation to this application.

Do you have an available prescriber?* ☐ Yes ☐ No

If yes, please select which kind:

☐ MD

☐ DO

☐ PA

☐ NP

Rationale for request

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Please provide any specialties as well as any other information to be considered in this application:*

Additional request details

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If you are a provider of services specifically for traumatic brain injury and/or intellectual and developmental disabilities for the following services: **day supports, residential supports and supported employment**, you must submit a home and community based services (HCBS) self-assessment.

Have you submitted the self-assessment in the HCBS portal?* ☐ Yes ☐ No

Member information sheet

Please complete this section if you are new provider, out-of-network provider or contracted provider making a member specific request.

10

Member last name:	_____	Member first name:	_____
Date of birth mm/dd/yyyy:	_____		
Member address line 1	_____	Address line 2	_____
Street, P.O. Box, etc.		Suite, Building, etc.	
City	_____	State	_____
	_____	Postal code	_____
Medicaid number:	_____	Requested effective date:	_____
Codes requested for member: _____			
Are you working with care coordination for this member? ☐ Yes ☐ No			
If yes, please provide care coordinator's name: _____			

Member last name:	_____	Member first name:	_____
Date of birth mm/dd/yyyy:	_____		
Member address line 1	_____	Address line 2	_____
Street, P.O. Box, etc.		Suite, Building, etc.	
City	_____	State	_____
	_____	Postal code	_____
Medicaid number:	_____	Requested effective date:	_____
Codes requested for member: _____			
Are you working with care coordination for this member? ☐ Yes ☐ No			
If yes, please provide care coordinator's name: _____			

Member last name:	_____	Member first name:	_____
Date of birth mm/dd/yyyy:	_____		
Member address line 1	_____	Address line 2	_____
Street, P.O. Box, etc.		Suite, Building, etc.	
City	_____	State	_____
	_____	Postal code	_____
Medicaid number:	_____	Requested effective date:	_____
Codes requested for member: _____			
Are you working with care coordination for this member? ☐ Yes ☐ No			
If yes, please provide care coordinator's name: _____			

📎 If you are including information for more than 3 members, please attach additional documentation to the application.

Authorization of person submitting request

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Print name:*	_____	
Signature (name or typed):*	Date (mm/dd/yyyy):*	
x		

Contract information

12

Name and email where contract needs to be sent for authorized signature:			
First name:*	_____	Last name:*	_____
Phone:*	_____	Fax:	_____
Website address (URL):	_____	Email:*	_____

Submission instructions

Please submit all completed applications and applicable attachments via secure email to enrollment@AllianceHealthPlan.org.