NORTH CAROLINA DIVISION OF HEALTH BENEFITS
SUPPLEMENT TO
PROVIDER AGREEMENT for HOSPITALS MAKING PRESUMPTIVE ELIGIBILITY DETERMINATIONS

AUTHORIZED INDIVIDUALS

_____/_____
Name of Hospital NPI Number

_____/_____
Physical Address Contact Person

_____/_____
Mailing Address Phone Number

Please list below the names and NCIDs of individual hospital staff persons seeking authorization to make Presumptive Eligibility determinations. (Use a supplemental continuation sheet if necessary and attach to this sheet.)

Employee Name	NCID

CERTIFICATION

By my signature below, I attest to my attendance and my completion of the required training and my understanding of program requirements.

Printed Name	Signature	Date