Instructions

Welcome to the Connecticut Medical Assistance Program Provider Enrollment/Re-enrollment Wizard. This Wizard is available to providers newly enrolling in the program and those providers who are notified that it is time for re-enrollment into the program. This Wizard offers a simplified, expedited method of enrollment/re-enrollment.

Please note the following:

- Providers must enroll in the appropriate taxonomy/provider type/specialty to ensure accurate billing and reimbursement rates. A full list of taxonomies/provider types/provider specialties can be found at **www.ctdssmap.com** by clicking on Information, then Publications.
- The Wizard will not allow you to submit an incomplete application. If required fields are omitted, you will be prompted during the application process to correct those fields.
- If you have a popup blocker, you must add **"www.ctdssmap.com"** as Allowed Web Site.
- Once you have started an application, you cannot save an application in process and return to complete it later. Rather, you will be required to start a new application.
- Applicants may be presented with a Follow On Document which lists additional documentation that must be mailed to the Hewlett Packard Enterprise Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to Hewlett Packard Enterprise any of the required documents will result in a delay in processing your application.
- Once an application has been submitted, you cannot return to it to modify the application. Any changes to the application after it has been submitted must be mailed to:

Hewlett Packard Enterprise
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104

This is the first page, just click next

Exceptions to Web Enrollments:

The Wizard is available to all provider groups and provider taxonomy/type/specialties, with the exception of the following:

- Private Non-Medical Institution Billing and Performing Providers
- Regional Family Service Coordination Center (RFSCC) (Birth to Three) Billing and Performing Providers
- Personal Care Services
- Employment and Day Support Waiver Billing and Performing Providers
- Connecticut Home Care (CHC) Personal Care Assistant (PCA) Fiduciary
- Mental Health Waiver Performing Providers
- Autism Waiver Performing Providers
- Early Childhood Autism Waiver Billing and Performing Providers

Note to Out-of-State Providers:

Out-of State providers that provide services to children who are enrolled in programs equivalent to a Department of Children & Family or a department such as a Department of Developmental Services, currently seeking enrollment in the Connecticut Medical Assistance Program, may do so using the Enrollment/Re-enrollment Wizard.

All other out-of-state providers may use the Enrollment/Re-enrollment Wizard if they have received approval from the Department of Social Services. Out-of-state providers may obtain approval by first submitting the claims for which they seek reimbursement to Hewlett Packard Enterprise at the following address:

Hewlett Packard Enterprise
Written Correspondence
OOS Claims
P. O. Box 2991
Hartford, CT 06104

Please click the "next" button to start the enrollment application.

Next Exit

New Providers are considered Organization/Group

Application Type

Required fields are indicated with an asterisk (*)

Type of Application *

- ○ Individual
- ◉ Organization/Group

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Because DDS does the Medicaid Billing for our providers, Please select "Organization that is Employed/Contracted by Another Organization

Organization Participation Type

Required fields are indicated with an asterisk (*).

Please indicate how you wish to participate in the Connecticut Medical Assistance Program:*

- ○ Organization
- ◉ Organization that is Employed/Contracted by Another Organization

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DEFINITIONS:

Organization - An organization provider would be an entity who is considered the biller and performer of service. An example would be a hospital provider or an agency that bills on behalf of other providers. Reimbursement is made to the organization.

Organization that is Employed/Contracted by Another Organization - An organization that is associated to another entity that is responsible for billing the services provided. An example would be a group home for which services are billed through a State agency. Reimbursement is made to the billing entity.

New Providers will select initial enrollment

Application For

Required fields are indicated with an asterisk (*)

This Application is for *

(•) Initial Enrollment
( ) Re-enrollment

* Initial Enrollment should be selected when the applicant has never participated in the Connecticut Medical Assistance Program. Initial Enrollment should not be selected if the applicant is now or was ever actively enrolled. Initial Enrollment is not a means to join another organization such as a group, clinic, or outpatient hospital. If an Initial Enrollment application is received from a provider who is currently on file, regardless of their current participation status, the application will not be processed. The provider will be instructed to re-enroll in the program by contacting the Provider Assistance Center at 1-800-842-8440 for assistance in obtaining an Application Tracking Number (ATN) needed for re-enrollment.

* If you have been notified that it is time for re-enrollment, please select Re-enrollment. You will need your Application Tracking Number (ATN) and NPI or Non-medical provider identifier (AVRS ID) in order to re-enroll. Your ATN is found on your re-enrollment letter or you can contact the Provider Assistance Center at 1-800-842-8440 for assistance in obtaining your ATN. If you have previously been enrolled in the Connecticut Medical Assistance Program and are attempting to re-join, you must first contact the Provider Assistance Center to obtain an ATN so that you may re-enroll.

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All DDS Providers need to select the below provider type and provider specialty

Provider Type/Specialty

Required fields are indicated with an asterisk (*)

Provider Type* BHH/TCM/Waiver Performing Provider

Provider Specialty* DDS TCM Performing Provider

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Before You Continue

Prior to continuing, it may be helpful to gather the following information which may be required on subsequent panels.
Click on the links below to open a sample of a completed enrollment application.

- Full 9 digit zip codes for all addresses
- License Number
- Out of state providers must submit a copy of their license to Hewlett Packard Enterprise. This documentation must contain the Application Tracking Number (ATN) assigned at the end of this enrollment.
- Tax Identification (including SSN and date of birth for all stakeholders, including owners, partners)
- National Provider Identifier (NPI)
- Taxonomy Code
- Direct Deposit Bank information (for providers seeking direct reimbursement)
- CLIA Number(s) (if applicable)
- Medicare Number (if applicable)
- Physician Assistant's Supervising Physician's Name, NPI, License
- Out of state provider wishing to enroll must first submit a claim to Hewlett Packard Enterprise
- The data you are required to enter may vary based on your provider type. The examples below demonstrate the maximum information that will be required from providers. A link to a sample application is provided below.

This screen shows what you may need in order to complete the application. You will not need all of the items on this list. DDS suggests looking through this PDF to see the screens and information that you will need.

Reminder: The application needs to be completed in one session since it cannot be saved to be completed at a later time.

Click here to open the Individual Practitioner Enrollment Application Sample
Click here to open the Employed by Organization Enrollment Application Sample
Click here to open the Organization Enrollment Application Sample
Click here to open the Organization Employed/Contracted by Org Enrollment Application Sample

- Applicants may be presented with a Follow On Document which lists additional documentation that must be mailed to the Hewlett Packard Enterprise Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to Hewlett Packard Enterprise any of the required documents will result in a delay in processing your application.

Residents Only: Please note that many of the bulleted items above do not apply to residents. However, it may be helpful to gather the following before continuing: National Provider Identifier (NPI), sponsoring institution's address to include the full 9 digit zip code, and your Social Security Number.

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National Provider Identifier Information

Required fields are indicated with an asterisk (*)

National Provider Identifier

Primary Taxonomy* ---------- - Taxonomy Not Applicable (non-medical services)

Taxonomy 2

Taxonomy 3

Taxonomy 4

Taxonomy 5

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"National Provider Identifier" should be left blank. Please select "Taxonomy Not Applicable (non-medical services)" as the Primary Taxonomy

Identifying Information

- The name entered on this line must match exactly the provider name submitted to the Internal Revenue Service and what is submitted on all other information supplied to the Connecticut Medical Assistance Program.
- Indicate the date the provider wishes to become effective. This date cannot be further back than six months.
- Indicate the language(s) spoken by organization staff that is available to interpret for clients.

Enter the name of your provider and the effective date. This date can only be backdated six months. For new providers enter the date that your provider was qualified by DDS

Required fields are indicated with an asterisk (*)

Name - Organization* Mystery Inc

Provider Effective Date* 09/01/2016

Languages
- [x] English
- [ ] Spanish
- [ ] Portuguese
- [ ] Russian
- [ ] Polish
- [ ] Other

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Addresses

Required fields are indicated with an asterisk (*).

Service Location Address

- Medicaid Contact Person and Telephone Number for Contact Person will be used for Medicaid administrative purposes only.
- Service location is the street address where a provider office is physically located and where the records are normally kept.
- Residents are required to provide the address of their sponsoring institution. Please note that street address line 2 may include specific information to ensure any letters mailed reach the appropriate staff/department at the resident's sponsoring organization.

Service Location Address

Street Address Line 1*	Bussiness Office Address
Street Address Line 2	
City*	Enfield
State/ZIP*	CT 01001 - 0215
Contact Person*	Fred Jones
Telephone Number - Contact Person*	(860)418-6000 Ext.
Telephone Number - For Patient Use*	(860)418-6000 Ext.
Handicap Accessible?	No
Contact Email	
Confirm EMail	
Fax	
TDD/TTY	

For New Providers - Enter the Business Office Address

Mailing Address

- Indicate the address where the Connecticut Medical Assistance Program should send general information and correspondence.

Mailing Address

Street Address Line 1*	Bussiness Office Address
Street Address Line 2	
City*	Enfield
State/ZIP*	CT 01001 - 0215
Contact Person*	Fred Jones
Telephone Number - Contact Person*	(860)418-6000 Ext.
Contact Email	
Confirm EMail	
Fax	

For New Providers - Enter the Business Office Address

Clear | Copy Svc Loc Addr

Home Office Address

- Indicate the provider's Home Office address.

Home Office Address

Street Address Line 1*	Bussiness Office Address
Street Address Line 2	
City*	Enfield
State/ZIP*	CT 01001 - 0215
Contact Person*	Fred Jones
Telephone Number - Contact Person*	(860)418-6000 Ext.
Contact Email	
Confirm EMail	
Fax	

For New Providers - Enter the Business Office Address

Clear | Copy Svc Loc Addr

Enrollment Address

- Enrollment address is the address to which all enrollment/re-enrollment correspondence will be mailed, including a provider's notice to re-enroll. If a provider has a central credentialing unit or office member that performs that function, this is the information that should be reflected in the address and contact fields below.

Enrollment Address

Street Address Line 1*	Bussiness Office Address
Street Address Line 2	
City*	Enfield
State/ZIP*	CT 01001 - 0215
Contact Person*	Fred Jones
Telephone Number - Contact Person*	(860)418-6000 Ext.
Contact Email	
Confirm EMail	
Fax	

For New Providers - Enter the Business Office Address

Clear | Copy Svc Loc Addr

Previous | Next | Exit

Additional Service Location Address

Required fields are indicated with an asterisk (*).

Street Address Line 1 | Street Address Line 2 | City | State | Contact Person | Telephone Number - Contact Person

Type changes below.

This screen should not be completed by DDS providers.
Leave Blank and Click Next.

Street Address Line 1*
Street Address Line 2
City*
State/ZIP* CT -
Contact Person*
Telephone Number - Contact Person* Ext.
Handicap Accessible? No
Contact Email
Confirm EMail
Fax
TDD/TTY

add cancel

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Enter in your Tax ID and effective date

Tax ID Information

Required fields are indicated with an asterisk (*)

Taxpayer Identification Number (TIN) Do not enter dashes *	XXX-XX-0111
TIN Effective Date*	10/01/2012

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Connecticut Department of Social Services
Making a Difference

Help
Tuesday, January 17, 2017

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search provider fee schedule download ehr incentive program
oos instructions/information e-mail subscription secure site

Instructions » Application Type » Organization Participation Type » Application For Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Identifying Information Addresses » Additional Service Location Address » Tax ID Information » **Member of Organization**

~~The next four slides on this PDF are of the same screen. Please look through all four~~ slides before proceeding. The fourth page is this series of slides shows all Organization IDs that new providers need to enter

Member of Organization

Required fields are indicated with an asterisk (*).

1. Type in the first ID "004230504". A panel will pop up on the bottom of the screen.

Please select the following link to obtain a list of the Organization IDs provided under each of the DDS waiver programs: Billing Provider Cross Reference DDS.

2. Click on the line circled below.

- If the applicant is a member of an organization, such as a group, clinic or hospital, indicate the organization to which they are a member.

Organization ID	Organization Name	Organization Membership Effective Date
004230504		

Type changes below.

Member of Organization

Organization ID* 004230504

add cancel

Organizations

Organization Name	Type	Specialty	Address	City	State	Zip
Other						
STATE OF CONNECTICUT	53 - BHH/TCM/Waiver Billing Provider	531 - DDS Comp Waiver Biller	460 CAPITOL AVENUE ,	HARTFORD	CT	06106-1308

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Member of Organization

Required fields are indicated with an asterisk (*).

3. Enter in the same effective date that was entered earlier in the application.
4. Click add

Please select the following link to obtain a list of the Organization IDs provided under each of the DDS waiver programs: Billing Provider Cross Reference DDS.

- If the applicant is a member of an organization, such as a group, clinic or hospital, indicate the organization to which they are a member.

Organization ID	Organization Name	Organization Membership Effective Date
004230504		

Type changes below.

Member of Organization

Organization ID* 004230504

Organization Name STATE OF CONNECTICUT

Organization Membership Effective Date*

add cancel

Organizations

Organization Name	Type	Specialty	Address	City	State	Zip
Other						
STATE OF CONNECTICUT	53 - BHH/TCM/Waiver Billing Provider	531 - DDS Comp Waiver Biller	460 CAPITOL AVENUE ,	HARTFORD	CT	06106-1308

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This screen shows a completed entry of a single Organization ID. The next page of the PDF shows all Organization IDs that need to be entered.

Member of Organization

Required fields are indicated with an asterisk (*).

Please select the following link to obtain a list of the Organization IDs provided under each of the DDS waiver programs: Billing Provider Cross Reference DDS.

- If the applicant is a member of an organization, such as a group, clinic or hospital, indicate the organization to which they are a member.

Organization ID	Organization Name	Organization Membership Effective Date
004230504	STATE OF CONNECTICUT	09/01/2016

Type changes below.

Member of Organization

Organization ID*

add cancel

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New Providers - Enter all 7 Organization IDs below

Member of Organization

Required fields are indicated with an asterisk (*).

Please select the following link to obtain a list of the Organization IDs provided under each of the DDS waiver programs: Billing Provider Cross Reference DDS.

- If the applicant is a member of an organization, such as a group, clinic or hospital, indicate the organization to which they are a member.

Organization ID	Organization Name	Organization Membership Effective Date
008033590	C/O ALLIED C R MFP IFS WAIVER	09/01/2016
008033591	C/O ALLIED C R MFP COMPREHENSIVE WAIVER	09/01/2016
008039317	STATE OF CT-MONEY FOLLOWS IFS	09/01/2016
008039318	STATE OF CT-MONEY FOLLOWS COMP	09/01/2016
008030810	DDS EMPLOYMENT AND DAY SUPPORTS WAIVER	09/01/2016
004247509	STATE OF CT IFS WAIVER	09/01/2016
004230504	STATE OF CONNECTICUT	09/01/2016

Type changes below.

Member of Organization

Organization ID*

add cancel

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Read the agreement and answer the two questions

Attestation

Required fields are indicated with an asterisk (*)

Electronic Signatures

Do you store your health records electronically? * (•) Yes ( ) No

Electronic Signature Attestation:

Conditions for DSS Acceptance of Electronic Signatures

In order for DSS to accept electronic signatures on the Provider's medical records, the Provider shall, at a minimum, meet the requirements that are listed below. In addition, the Provider shall have written policies governing the assignment and use of electronic signatures on medical records that reflect these requirements. The requirements are as follows:

In order to authenticate and safeguard confidentiality of electronic signatures, the Provider shall assign each User of an electronic signature ("User") at least two (2) distinct identification components, such as an identification code and a password, which, together, shall constitute a "unique code." For the purposes of this Addendum, the User's name will not suffice as a password.

Before assigning the unique code, the Provider shall verify the identity of the User.

The unique code assigned by the Provider to a User shall not be assigned to anyone else.

The Provider shall certify, in writing, that the User is the only person authorized by the Provider to use the unique code that was assigned to him or her.

Each User shall certify, in writing, that, the User will not release his/her User identification code or password to anyone, or allow anyone to access or alter information under his/her identity.

Each Provider and each User shall certify, in writing, that the electronic signature is intended to be the legally binding equivalent of the User's traditional handwritten signature.

(•) Yes. I certify that the Provider has policies that meet the Provider Enrollment Agreement concerning the Acceptable Use of Electronic Signature requirements for acceptance of electronic signatures by DSS, and that the Provider meets all of the requirements for the issuance and use of electronic signatures.

( ) No, I do not certify that I meet the requirements for acceptance of electronic signatures by DSS.

Only enter yes if your provider provides Medicare Services

Medicare Information

Required fields are indicated with an asterisk (*)

Are you enrolled in Medicare? ○ Yes ◉ No

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Board Members, Partners or Managing Administrators Information

Enter the information for all Board Members, Partners and Managing Administrators.

Required fields are indicated with an asterisk (*)

Are you a nonprofit organization or an organization without an owner?* ○ Yes ◉ No

Are there board members, partners, or managing administrators of your organization?* ◉ Yes ○ No

For both nonprofit and profit organizations: If an organization has a board of directors (either paid or volunteer), the provider must supply the information for the administrative staff. The person(s) responsible for the day to day operations of the organization would include: President, VP, Treasurer, CEO, managing partners, etc.

Do all owners have less than 5% ownership in the organization? ○ Yes ◉ No ○ N/A

Is your corporation a subsidiary of another company?* ○ Yes ◉ No

Name: Mystery Inc.

Corporate Headquarters Location: Business Office Address

Board Members, Partners, or Managing Administrators Information-Detail

Position	Name	City	State
Chief Executive Officer	Jones, Fred	Enfield	CT

Select row above to update -or- click Add button below.

Required fields are indicated with an asterisk (*)

Position*: Chief Executive Officer

Last name*: Jones

First Name, Middle Initial*: Fred

Street Address Line 1*: 49 Miner Lane

Street Address Line 2:

City*: Enfield

State/ZIP*: CT 01001 - 0215

SSN*: XXX-XX-3333

Date of Birth*: XX/XX/1980

Delete Save

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Controlling Interest

Required fields are indicated with an asterisk (*).

- If you are a nonprofit organization or an organization without an owner, controlling interest information is not required.
- Indicate the person/persons who have a controlling interest in your organization.
- **Controlling Interest:** Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 5% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

Name	Percentage of Controlling Interest
Jones, Fred	0.5
Jones, Nicholas	0.5

Type data below for new record.

Last Name* Jones
First Name* Nicholas
Middle Initial
Relationship* Sibling
Medicaid Provider Number (if applicable)
Social Security Number* XXX-XX-5555
Date of Birth* XX/XX/1975

Enter all Owners that own 5% or more of the company.

Street Address Line 1* 50 Zombo Rd
Street Address Line 2
City* Enfield
State/ZIP* CT 01001 - 0215

Telephone Number - Business* (860)418-6000 Ext.
Percentage of Controlling Interest* 50%

delete save

The percentage of ownership does not equal 100%. The remaining owners have less than 5% ownership in the organization. ◉ Yes ○ No

Does the applicant and/or owner, partner, member or officer have an ownership or controlling interest in any other provider? * ○ Yes ◉ No

Required fields are indicated with an asterisk (*)

Answer all survey questions

1. Is, or was, applicant a Medicaid provider in any other state? *	○ Yes ◉ No
2. Is applicant a provider for any other federal program, e.g., MEDICARE? *	○ Yes ◉ No
3. Has the applicant ever been denied enrollment in Medicaid, Medicare or any other state or federal program? *	○ Yes ◉ No
4. Does applicant contract with any private health insurance providers? *	○ Yes ◉ No
5. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family or marriage? *	○ Yes ◉ No
6. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family, marriage, ownership, membership, control, or business relationship to any other provider that is currently, or within the last 5 years, has been, enrolled in the Connecticut Medical Assistance Program? *	○ Yes ◉ No
7. Does applicant, and/or any owner, partner, member, officer, director, shareholder, or managing employee of provider owe money to the federal government and/or any State for Medicare and/or Medicaid involvement in the past? *	○ Yes ◉ No
8. Has applicant and/or any owner, associate, partner, member, officer, director, shareholder, or managing employee ever filed bankruptcy on behalf of a business which participated in a State or Federal Medical Assistance Program? *	○ Yes ◉ No
9. Is applicant and/or owner, partner, member, or officer, currently in bankruptcy? *	○ Yes ◉ No
10. Has there been any disciplinary, administrative, civil, or criminal actions taken against applicant, a family member, partner, member, director, officer or managing employee in any way related to the provision of health care goods or services, including but not limited to those goods or services covered by Medicare or Medicaid? *	○ Yes ◉ No
11. Is applicant a salaried employee of a hospital, clinic, or institution? *	○ Yes ◉ No
12. Does applicant provide contractual services to a hospital, clinic, or institution? *	○ Yes ◉ No
13. If you are re-enrolling, has there been a change in ownership or control of 5% or greater since your last enrollment? *	○ Yes ◉ No
14. Are you a contractor for an enrolled Connecticut Medical Assistance Program Provider? *	○ Yes ◉ No
15. Are you an employee of an enrolled Connecticut Medical Assistance Program Provider? *	○ Yes ◉ No

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Complete the three fields shown. Please do not click any links on the next page that refer to additional documentation. DDS providers do not need additional documentation. Please save the ATN number that is generated once you submit the application.

Summary

Click here to open Provider Enrollment Agreement

☑ **I agree that I have read and accept the terms of the Provider Enrollment Agreement.**

SSN of Person Signing the Application*	XXXXX3333
Signature of Provider or Authorized Representative*	Fred Jones

- The Application has been completed and is ready to submit. If any changes need to be made, please make them now by using this Web site's navigation links and command buttons (not the browsers navigation buttons).
- **IMPORTANT NOTICE:** In receiving this application from and granting Medicaid enrollment to the individual or other entity named as "Provider Applicant," the Connecticut Medical Assistance Program relies on the truth of all the following statements:

I certify that, if I am granted status as a provider for Connecticut Medical Assistance programs, I expressly agree to the following: to abide by all applicable federal and state statutes, regulations, policy transmittals, and provider bulletins; to keep accurate and current records regarding the nature, scope and extent of services furnished to Medical Assistance recipients; and to furnish information pertaining to any claim for Medicaid payment, whether made by me or on my behalf, to the Connecticut Department of Social Services, the Secretary of Health and Human Services, and the offices of the Connecticut Chief State's Attorney and the Connecticut Attorney General, or their agents, upon request. I will make such information available for inspection and/or copying, and/or will provide copies of such information, upon request.

I certify that I have legal authority to enter into contracts and agreements on behalf of the provider.

- After you submit the application, you will be able to print and/or save the application as a PDF.
- Select "Submit" to submit the application.

Previous Submit Exit