Instructions

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:

- As defined in 42 CFR 455.434, fingerprint-based background checks will be applied to providers and suppliers placed into the high level risk category during the enrollment or re-enrollment process.
- 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 Gainwell Technologies Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to Gainwell Technologies 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:

Gainwell Technologies
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06102-5007

This is the first page, just click next

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 Gainwell Technologies at the following address:

Gainwell Technologies
Written Correspondence
OOS Claims
P. O. Box 2991
Hartford, CT 06104

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

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Instructions » Application Type

New CCH Providers are considered Individuals

Application Type

Required fields are indicated with an asterisk (*)

Type of Application *

- (•) Individual
- ( ) Organization/Group

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Instructions » Application Type » **Participation Type**

Participation Type

Required fields are indicated with an asterisk (*).

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

- ○ Individual practitioner
- ◉ Employed/Contracted by an organization (to include **residents**)
- ○ Ordering/Prescribing/Referring provider only

Because DDS does the Medicaid Billing for our providers, please select: "Employed/Contracted by an Organization (to include residents"

Individual practitioner - An individual practitioner provider would be a single individual who is considered the biller and performer of service. An example would include a single physician office practice. Reimbursement will be made directly to the individual practitioner.

Employed/Contracted by an organization - A member of an organization such as a provider group, clinic, hospital outpatient clinic or FQHC would be a performing provider. **Residents** are also considered employed/contracted by an organization participation type and should select this radio button. The organization would bill for the services provided by the member/performer of the organization. Reimbursement will be made directly to the organization. Important: The organization and each member of the organization must enroll/re-enroll.

Ordering/Prescribing/Referring provider only - An individual provider who wishes to participate solely as an ordering or prescribing or referring provider who does not intend to bill or receive payment directly from the Connecticut Medical Assistance Program.

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Instructions » Application Type » Participation Type » **Application For**

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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Instructions » Application Type » Participation Type » Application For
Provider Type/Specialty

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 Gainwell Technologies. 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 Gainwell Technologies
- 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.

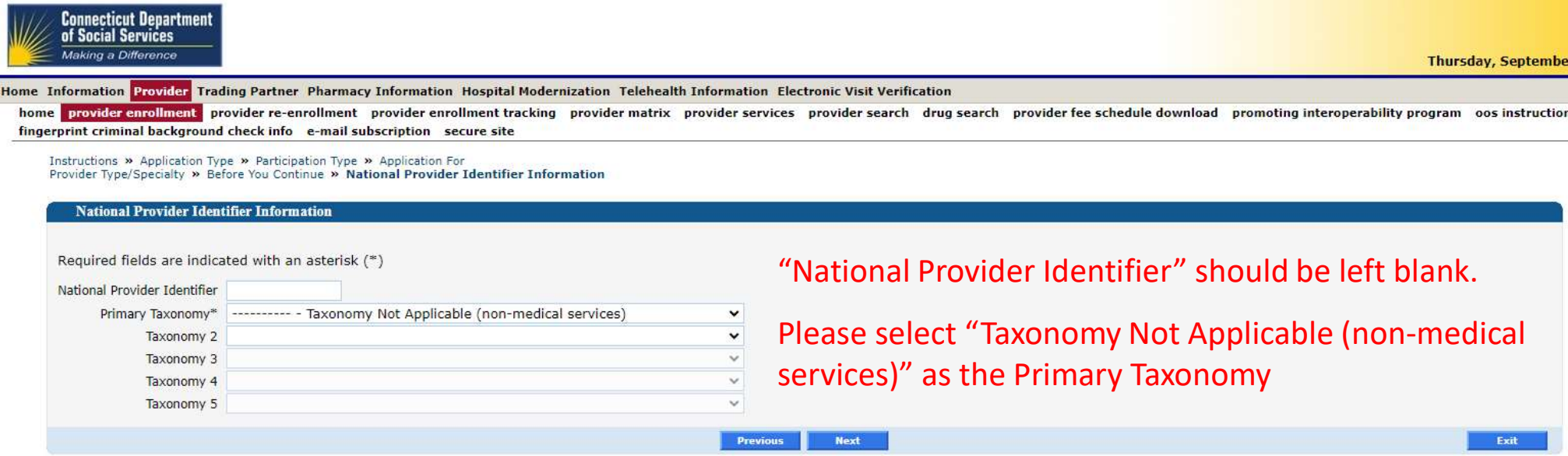
This screen shows what you may need in order to complete the application. You will not need all of the items on this list. DDS suggests looking through this PDF to see screens and information that you will need.

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 Gainwell Technologies Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to Gainwell Technologies 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, license/permit number, effective date and end date as issued by the Department of Public Health (DPH), and your Social Security Number.



"National Provider Identifier" should be left blank.

Please select "Taxonomy Not Applicable (non-medical services)" as the Primary Taxonomy

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Individual Name

- 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.

Required fields are indicated with an asterisk (*)

Insert the information of the primary license holder

Last Name*	Parker
First Name*	Peter
Middle Initial	
Date of Birth*	XX/XX/1993
Gender*	○ Female ◉ Male
Social Security Number*	XXX-XX-1234

Do not enter dashes.

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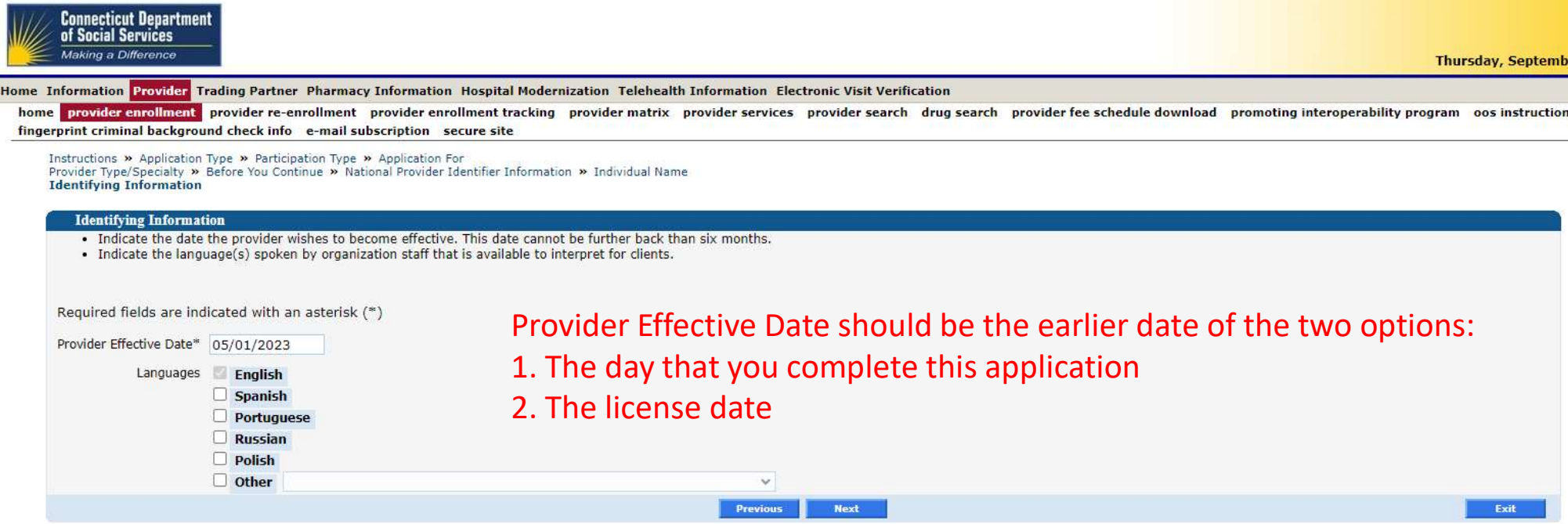

Provider Effective Date should be the earlier date of the two options:

1. The day that you complete this application
2. The license date

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Instructions » Application Type » Participation Type » Application For
Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name
Identifying Information » **Addresses**

Addresses

Required fields are indicated with an asterisk (*).

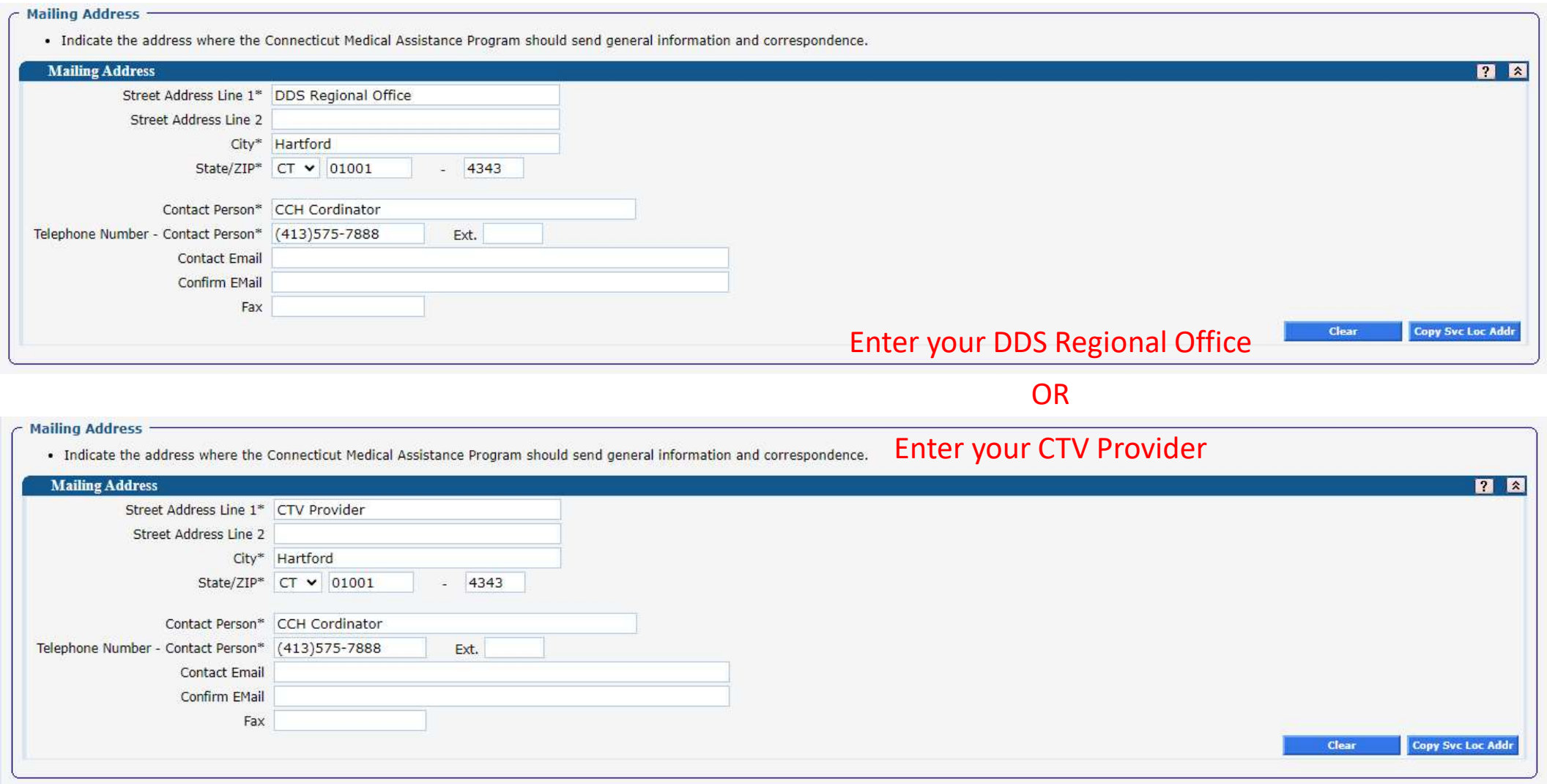
Service Location Address

- 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*	Location of CCH
Street Address Line 2	
City*	Hartford
State/ZIP*	CT 01001 - 4343
Contact Person*	Peter Parker
Telephone Number - Contact Person*	(413)575-7888 Ext.
Telephone Number - For Patient Use*	(413)575-7888 Ext.
Handicap Accessible?	No
Contact Email	
Confirm EMail	
Fax	
TDD/TTY	
Mobile Number	
Pager Number	

Enter the address listed on the license


Mailing Address
• Indicate the address where the Connecticut Medical Assistance Program should send general information and correspondence.
Mailing Address
Street Address Line 1* DDS Regional Office
Street Address Line 2
City* Hartford
State/ZIP* CT 01001 - 4343
Contact Person* CCH Cordinator
Telephone Number - Contact Person* (413)575-7888 Ext.
Contact Email
Confirm EMail
Fax
Clear
Copy Svc Loc Addr
Enter your DDS Regional Office
OR
Mailing Address
• Indicate the address where the Connecticut Medical Assistance Program should send general information and correspondence.
Enter your CTV Provider
Mailing Address
Street Address Line 1* CTV Provider
Street Address Line 2
City* Hartford
State/ZIP* CT 01001 - 4343
Contact Person* CCH Cordinator
Telephone Number - Contact Person* (413)575-7888 Ext.
Contact Email
Confirm EMail
Fax
Clear
Copy Svc Loc Addr

Home Office Address

- Indicate the provider's Home Office address.

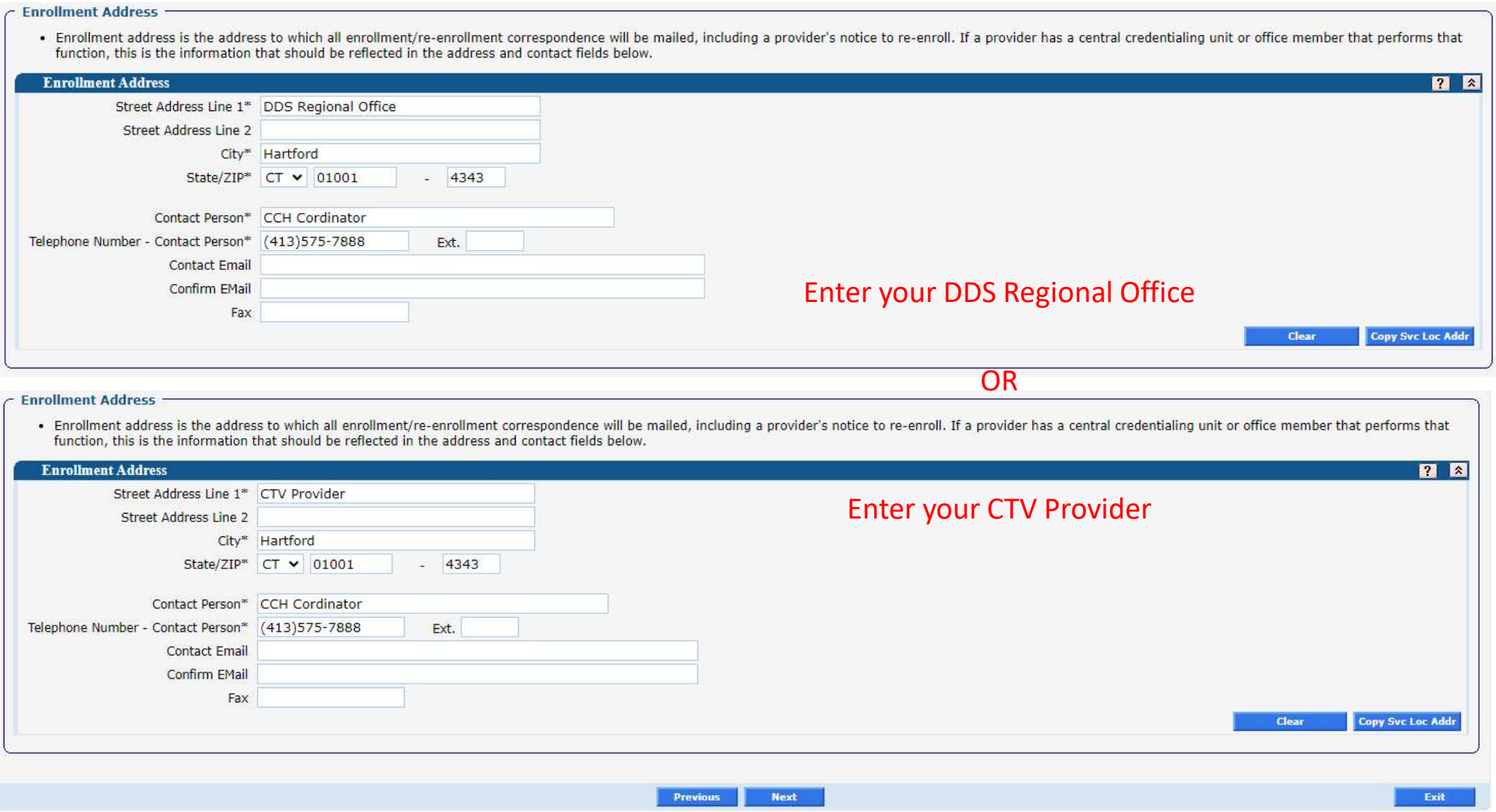
Home Office Address

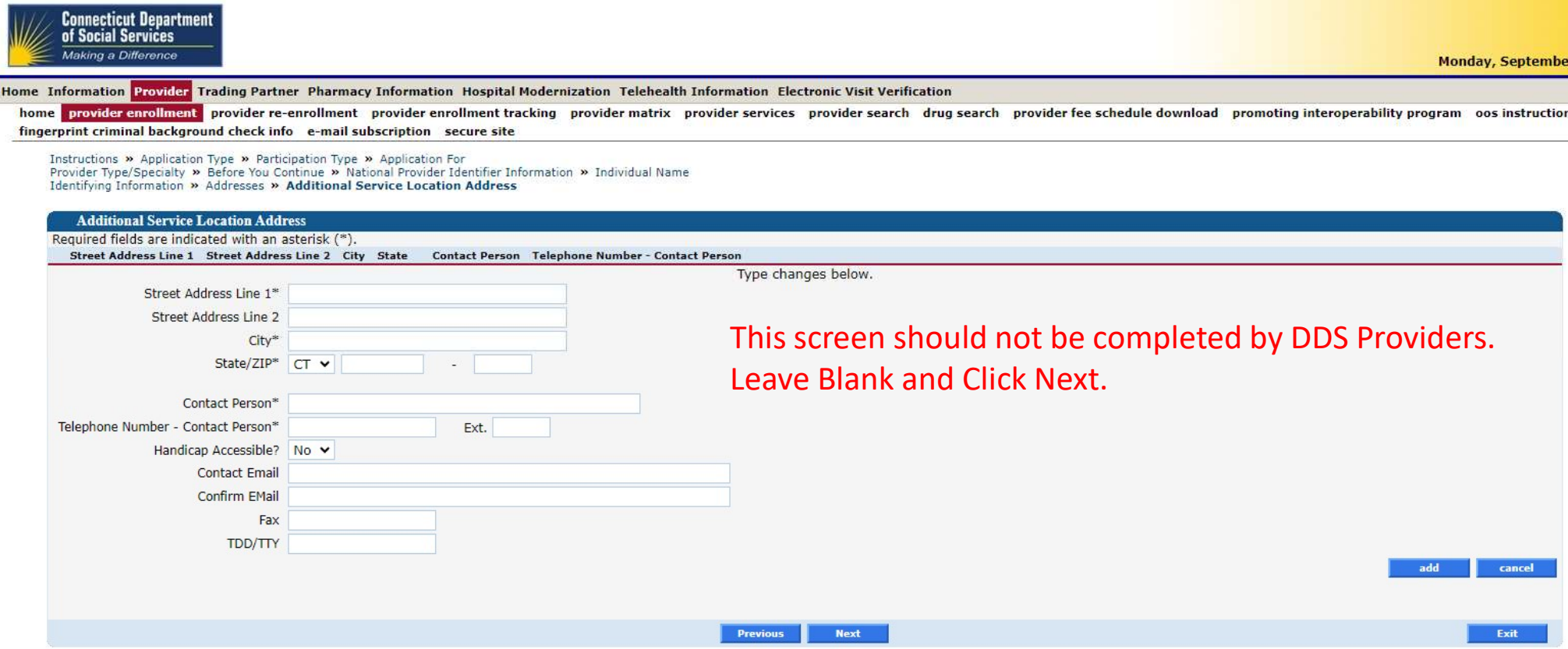
Street Address Line 1* Location of CCH
Street Address Line 2
City* Hartford
State/ZIP* CT 01001 - 4343

Contact Person* Peter Parker
Telephone Number - Contact Person* (413)575-7888 Ext.
Contact Email
Confirm EMail
Fax

Enter the address listed on the license

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* DDS Regional Office
Street Address Line 2
City* Hartford
State/ZIP* CT 01001 - 4343
Contact Person* CCH Cordinator
Telephone Number - Contact Person* (413)575-7888 Ext.
Contact Email
Confirm EMail
Fax
Enter your DDS Regional Office
Clear
Copy Svc Loc Addr
OR
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* CTV Provider
Street Address Line 2
City* Hartford
State/ZIP* CT 01001 - 4343
Contact Person* CCH Cordinator
Telephone Number - Contact Person* (413)575-7888 Ext.
Contact Email
Confirm EMail
Fax
Enter your CTV Provider
Clear
Copy Svc Loc Addr
Previous
Next
Exit



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

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Instructions » Application Type » Participation Type » Application For
Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name
Identifying Information » Addresses » Additional Service Location Address » **Facility**

Facility

Facility NPI | Facility Name | Street Address Line 1 | Street Address Line 2 | City | State

Type changes below.

The fields below should be used to indicate the facility's National Provider Identifier (NPI), as well as name and address that a postal service uses to identify a provider's facility.

Required fields are indicated with an asterisk (*)

Facility National Provider Identifier
Facility Name*
Street Address Line 1*
Street Address Line 2
City*
State/ZIP* -

Leave this page blank

add cancel

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Instructions » Application Type » Participation Type » Application For Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information

HIT/HIE Contact and EHR Information

- Your Health Information Technology (HIT)/Health Information Exchange (HIE) contact information should be supplied in the contact fields below.
- Information on your current Electronic Health Record (EHR) system is also required in the fields below.

Enter the name of the License Holder,
If you do not use an Electronic Health Record system, enter no

Contact Information

Contact First Name: Peter
Contact Last Name: Parker
Contact Phone: (413)575-7888 Ext:
Contact Email: peter.parker@gmail.com

EHR Information

Do you use an Electronic Health Record (EHR) system? (•) No ( ) Yes

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

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Instructions » Application Type » Participation Type » Application For
Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name
Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information » **Member of Organization**

1. Type in the first ID “004230504”.
   A panel will pop up on the bottom of the screen
2. Click on the line circled 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
004230504		

Type changes below.

Member of Organization

Organization ID* 004230504

add cancel

Organizations

- Please select the correct organization from this list. If the organization is not present, select Other and enter the organization's name and effective date of membership.

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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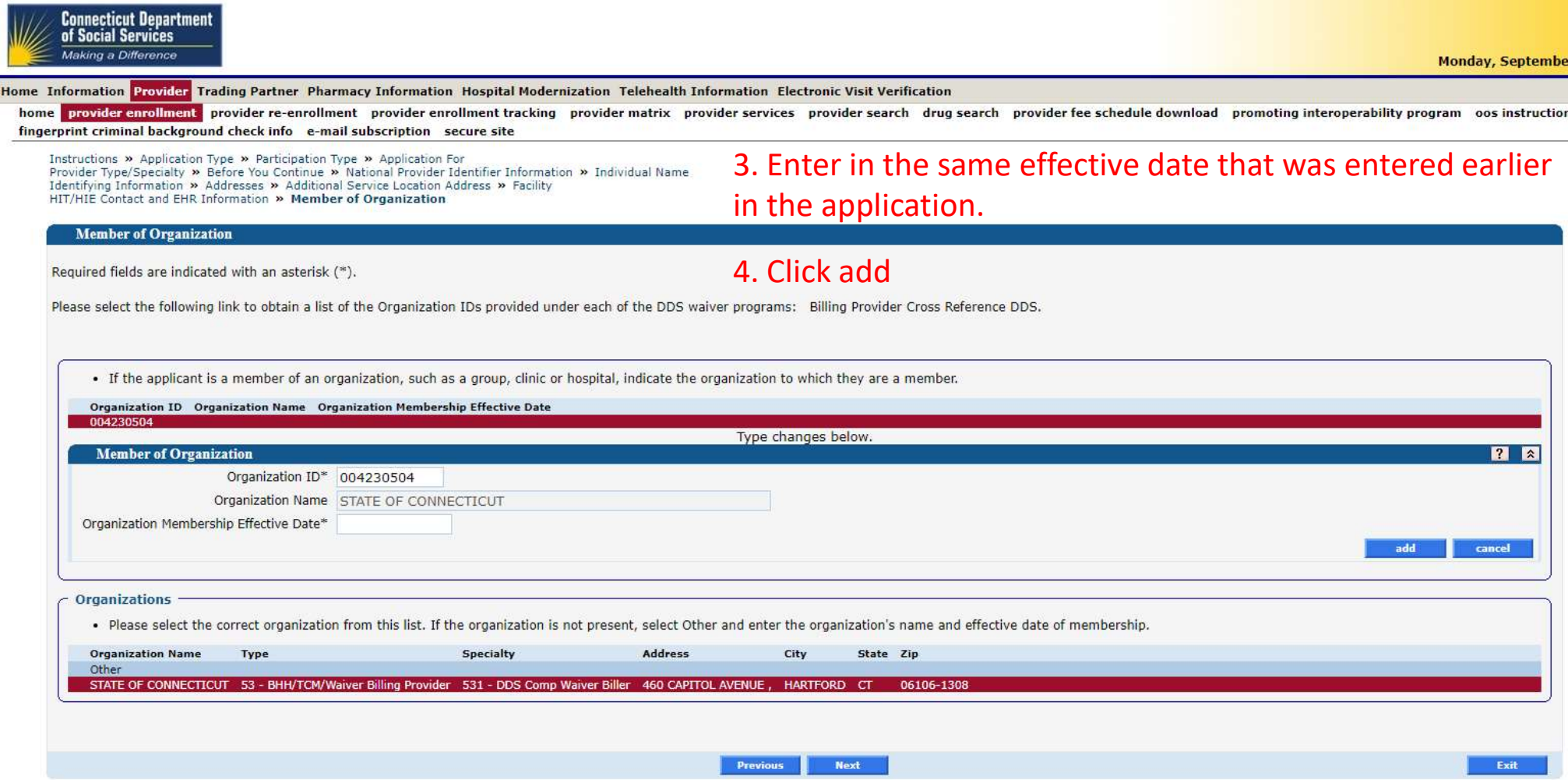
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Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name
Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information » Member of Organization
3. Enter in the same effective date that was entered earlier in the application.
Member of Organization
Required fields are indicated with an asterisk (*).
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
Please select the correct organization from this list. If the organization is not present, select Other and enter the organization's name and effective date of membership.
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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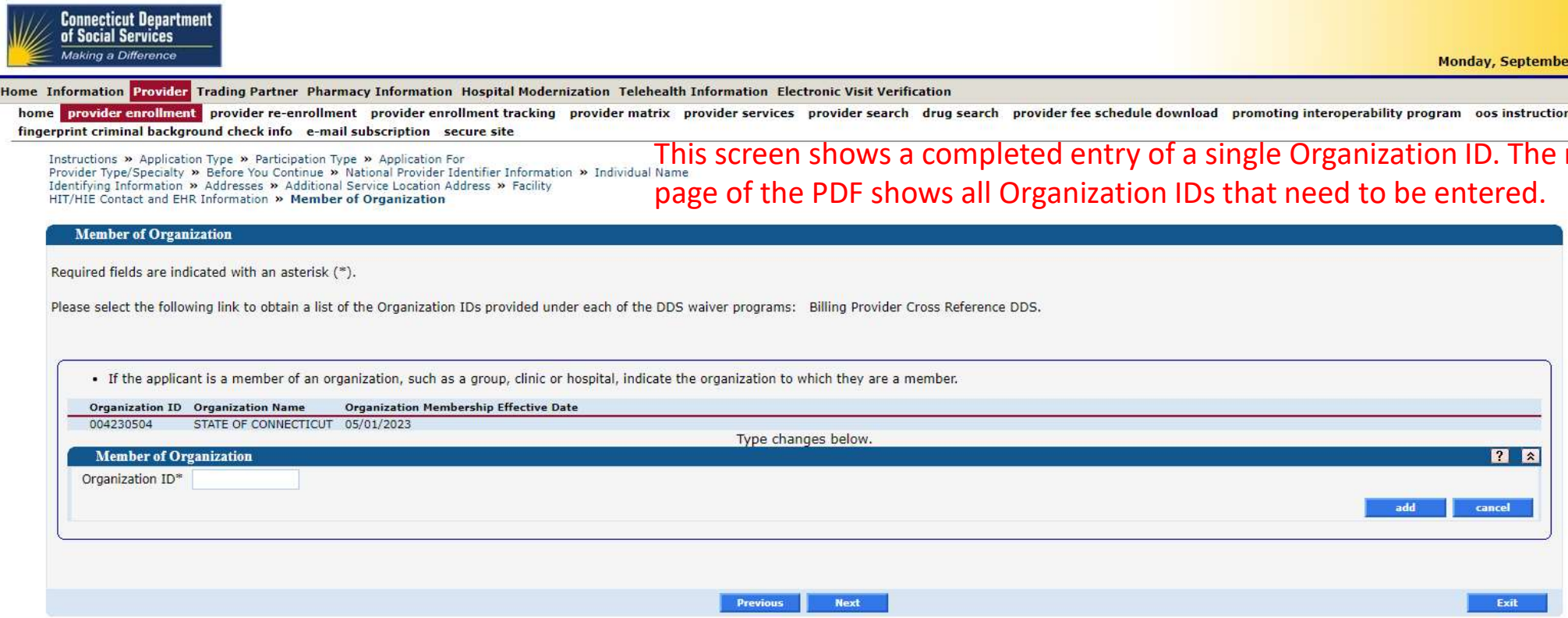
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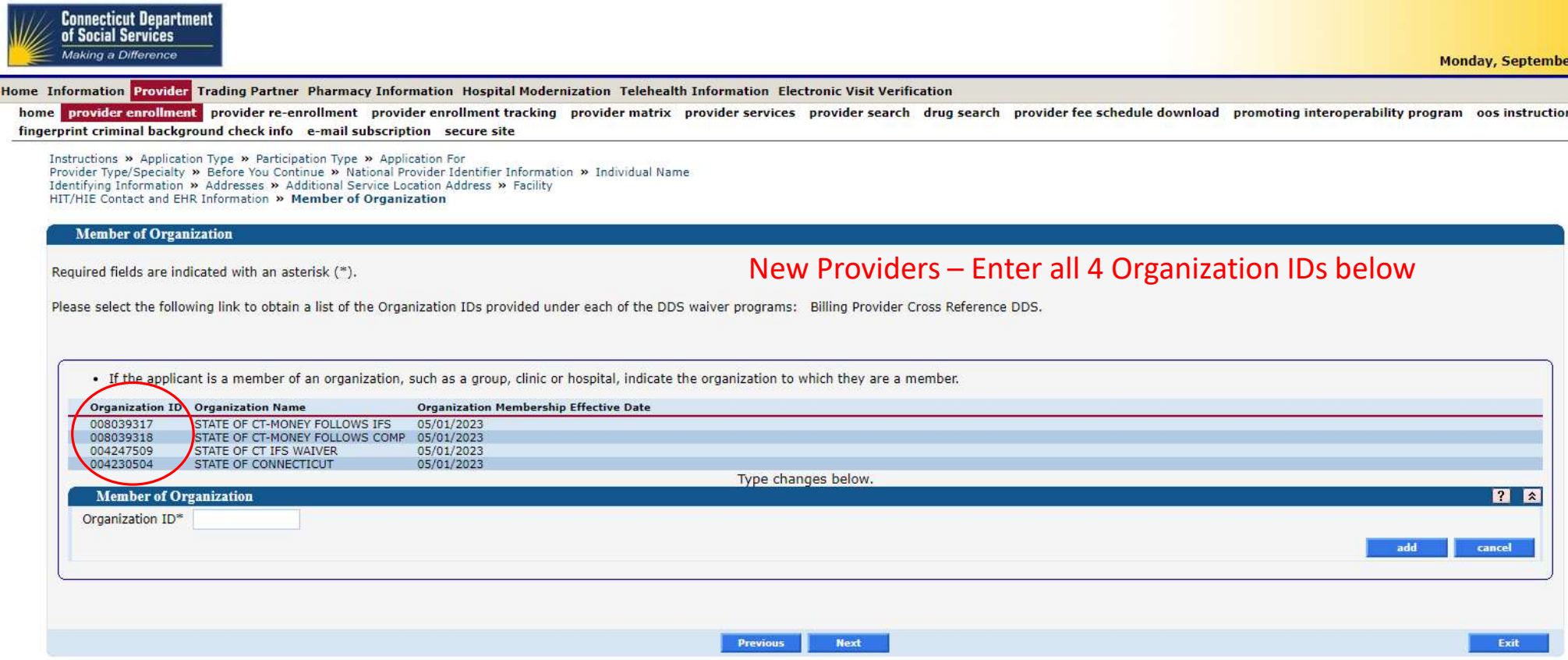
Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information » Member of Organization
This screen shows a completed entry of a single Organization ID. The next page of the PDF shows all Organization IDs that need to be entered.
Member of Organization
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
05/01/2023
Type changes below.
Member of Organization
Organization ID*
add
cancel
Previous
Next
Exit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Identifying Information » Addresses » Additional Service Location Address » Facility
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Member of Organization
Required fields are indicated with an asterisk (*).
New Providers – Enter all 4 Organization IDs below
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
008039317 STATE OF CT-MONEY FOLLOWS IFS 05/01/2023
008039318 STATE OF CT-MONEY FOLLOWS COMP 05/01/2023
004247509 STATE OF CT IFS WAIVER 05/01/2023
004230504 STATE OF CONNECTICUT 05/01/2023
Type changes below.
Member of Organization
Organization ID*
add
cancel
Previous
Next
Exit

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HIT/HIE Contact and EHR Information » Member of Organization » **Additional Information**

Additional Information

- Residents - Enter your DPH permit number and permit effective and end date.
- Non-Residents - Enter your license number and license effective and end date.

Required fields are indicated with an asterisk (*)

Leave this page blank

CLIA number 1
CLIA number 2
CLIA number 3
CLIA number 4
CLIA number 5

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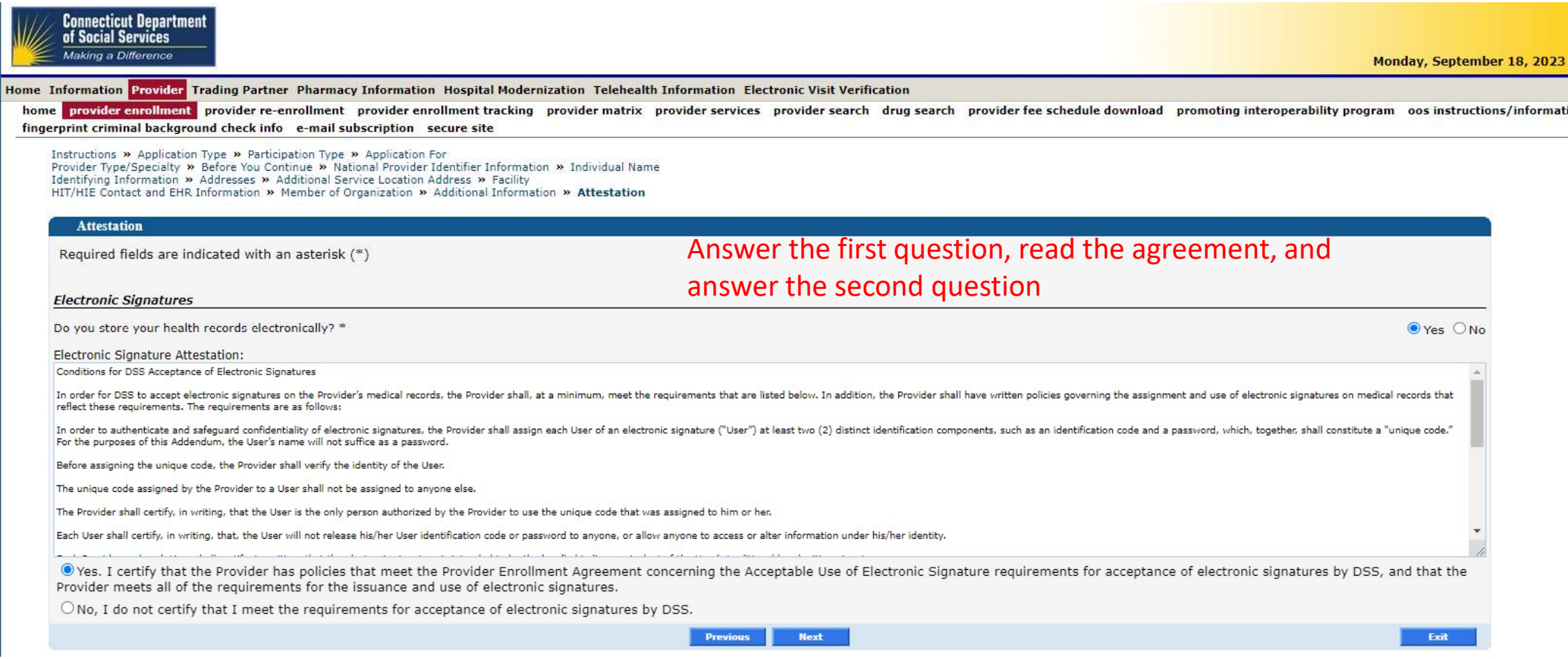
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Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information » Member of Organization » Additional Information » Attestation
Attestation
Required fields are indicated with an asterisk (*)
Answer the first question, read the agreement, and answer the second question
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.
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.
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Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name
Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information » Member of Organization » Additional Information » Attestation
Survey

Answer all survey questions

Survey

Required fields are indicated with an asterisk (*)

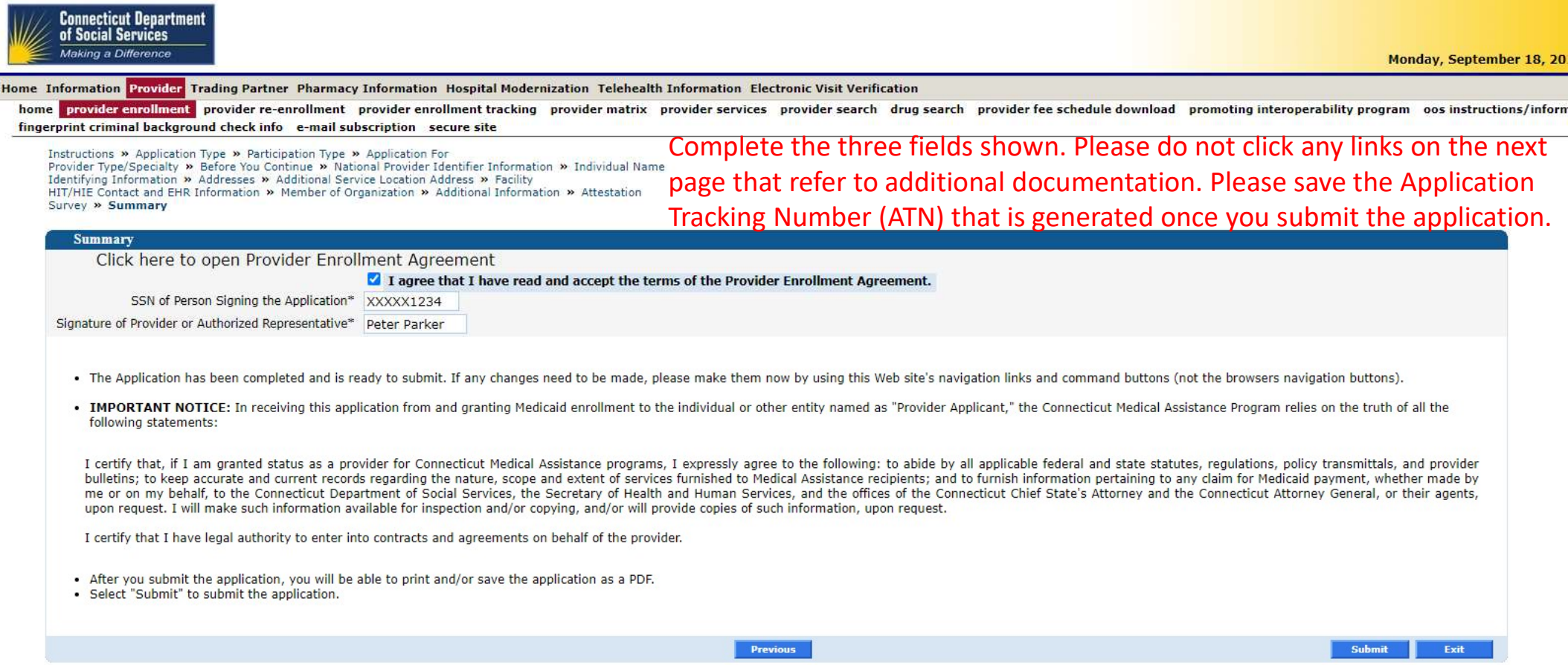
1. Is, or was, applicant a Medicaid provider in any other state? * ○ Yes ◉ No

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. 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

Previous Next Exit


Connecticut Department of Social Services
Making a Difference
Monday, September 18, 20
Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Telehealth Information Electronic Visit Verification
home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search provider fee schedule download promoting interoperability program oos instructions/inform
fingerprint criminal background check info e-mail subscription secure site
Instructions » Application Type » Participation Type » Application For
Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name
Identifying Information » Addresses » Additional Service Location Address » Facility
HIT/HIE Contact and EHR Information » Member of Organization » Additional Information » Attestation
Survey » Summary
Complete the three fields shown. Please do not click any links on the next page that refer to additional documentation. Please save the Application Tracking Number (ATN) 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*
XXXXX1234
Signature of Provider or Authorized Representative*
Peter Parker
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