

## 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](http://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](http://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

### Exceptions to Web Enrollments:

This is the first page, just click next

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.

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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**

Because DDS does the Medicaid Billing for our providers, Please select "Employed/  
Contracted by an organization (to include residents)"

### 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

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

### Provider Type/Specialty

Required fields are indicated with an asterisk (\*)

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Provider Specialty\*

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Instructions » Application Type » Organization Participation Type » Application For  
Provider Type/Specialty » **Before You Continue**

### 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.

[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.

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.

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Instructions » Application Type » Organization Participation Type » Application For  
Provider Type/Specialty » Before You Continue » **National Provider Identifier Information**

### National Provider Identifier Information

Required fields are indicated with an asterisk (\*)

National Provider Identifier	<input type="text"/>
Primary Taxonomy*	----- - Taxonomy Not Applicable (non-medical services) ▼
Taxonomy 2	▼
Taxonomy 3	▼
Taxonomy 4	▼
Taxonomy 5	▼

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

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

### 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\*

First Name\*

Middle Initial

Date of Birth\*

Gender\*  Female  Male

Social Security Number\*

Do not enter dashes.

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**Identifying Information**

### Identifying Information

- 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.

Required fields are indicated with an asterisk (\*)

Provider Effective Date\*

- Languages
- English
  - Spanish
  - Portuguese
  - Russian
  - Polish
  - Other

Provider Effective Date should be the earlier date of the two below options :  
1. The day that you complete this application  
2. The license date

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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\*

Street Address Line 2

City\*

State/ZIP\*   -

Contact Person\*

Telephone Number - Contact Person\*  Ext.

Telephone Number - For Patient Use\*  Ext.

Handicap Accessible?

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\*

Street Address Line 2

City\*

State/ZIP\*   -

Contact Person\*

Telephone Number - Contact Person\*  Ext.

Contact Email

Confirm EMail

Fax

Enter your DDS Regional Office

Clear

Copy Svc Loc Addr



## Home Office Address

- Indicate the provider's Home Office address.

### Home Office Address



Street Address Line 1\*

Street Address Line 2

City\*

State/ZIP\*   -

Contact Person\*

Telephone Number - Contact Person\*  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\*

Street Address Line 2

City\*

State/ZIP\*   -

Contact Person\*

Telephone Number - Contact Person\*  Ext.

Contact Email

Confirm EMail

Fax

Please enter your DDS Regional Office

Clear

Copy Svc Loc Addr

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Addresses » **Additional Service Location Address**

### 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.

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

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

add cancel

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

### HIT/HIE Contact and EHR Information

#### Contact Information

Contact First Name   
Contact Last Name   
Contact Phone  Ext   
Contact Email

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

#### 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 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 (\*).

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](#).

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.

- 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\*

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\*

Organization Name

Organization Membership Effective Date\*

#### 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 (\*).

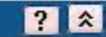
Please select the following link to obtain a list of the Organization IDs provided under each of the DDS waiver programs: [Billing Provider Cross Reference DDS](#).

- 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

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

### 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	05/01/2017
008039318	STATE OF CT-MONEY FOLLOWS COMP	05/01/2017
004247509	STATE OF CT IFS WAIVER	05/01/2017
004230504	STATE OF CONNECTICUT	05/01/2017

Type changes below.

### Member of Organization

Organization ID\*

add

cancel

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### Additional Information

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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**Attestation**

Read the agreement and answer the two questions

### Attestation

Required fields are indicated with an asterisk (\*)

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#### 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.

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Attestation » **Medicare Information**

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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Medicare Information » **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

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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 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\* 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.

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Submit

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