Connecticut Department of Social Services
Provider Enrollment/Re-enrollment Application and Agreement

Dear Provider:

The Department of Social Services (DSS) appreciates your interest in participating in the Connecticut Medical Assistance Program. **All applications must be submitted electronically via the Web portal at www.ctdssmap.com.** If you are unable to submit your application via the Web portal and wish to request an exception from DSS to allow a paper application to be submitted, please complete the following application. When mailing the completed application to Gainwell Technologies, please enclose a signed statement on your letterhead explaining the hardship preventing you from submitting the application online. If DSS approves your request, the application will be processed. If DSS denies the request to submit the application on paper, you will be contacted, and the application must then be submitted via the Web. To enroll/re-enroll via the Web Portal, go to **www.ctdssmap.com → Provider → Provider Enrollment or Provider Re-Enrollment**.

When completing this application, there may be additionally required documentation that must be attached. To determine the additional documentation that is required, providers may refer to the Web portal at **www.ctdssmap.com → Provider → Provider Matrix.**

If you enroll or re-enroll on the Web portal, please do not submit the printed copy of the application. You are only required to submit the documentation listed at the end of the Enrollment/Re-enrollment Wizard.

The following sections are intended to guide those providers that must enroll/re-enroll using this paper application.

- Please review the contents of the enclosed application carefully, completing all required sections and supplying all requested information.
- DSS requires the completed forms to be returned as soon as possible to ensure your enrollment/re-enrollment application is processed in a timely manner.
- Incomplete applications cannot be processed and will be returned.
- Mail completed application to:

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

Contact the Provider Assistance Center at 1-800-842-8440 if you have questions about this application.

The following definition of terms should assist you in completing the application:

- Organization Provider – An organization provider consists of more than one performer or member, such as a hospital, physician group, dental group, clinic, or state contracted access agencies. The organization would be the billing provider.

- 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. 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.

- 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.

- Ordering/Prescribing/Referring (OPR) Provider - A person who prescribes, refers or orders services for a client, yet does not intend to bill or receive payment directly from the Connecticut Medical Assistance Program, and who is not affiliated with an organization. Please note that OPR providers are required to complete a different version of the paper application. That version can be found under the Web Portal at www.ctdssmap.com > Information > Publications, then scroll down to the Provider Enrollment/Maintenance Form section and click the link for the Ordering, Prescribing, Referring Application.

Out-of-State Providers
Out-of-state providers may be enrolled at the Department's discretion. Please refer to Chapter 3 of the Provider Manual to review the process prior to submitting an enrollment application. This manual can be accessed on the Web portal at www.ctdssmap.com → **Information → Publications.**

The Application

The Application consists of Sections A through M, and includes the Provider Agreement as Section M.

For **Organization and Individual Practitioners as defined above**, please complete the application sections indicated below:

Section A: Type of Enrollment
Section B: Demographic/Provider Specific Information
Section C: Service Location and Facility Information
List primary service location, additional service locations, home office, mail to, pay to, enrollment and facility (for individual providers) locations. **Note**: A P.O. Box cannot be accepted as any part of the primary or additional service location addresses. Additionally, the zip +4 extension is a required field on all addresses. To obtain the last 4-digits of the zip code, a provider may access the United States Postal Service Web site at: http: //zip4.usps.com/zip4/welcome.jsp.
Section D: Provider Organization Information
Section E: Provider Questionnaire
Respond to each question in this section. Incomplete or unanswered questions will result in the application returned to you for completion.
Section F: False Claims Act Compliance Attestation
This section is to be completed by organizations/entities that receive more than $5,000,000 annually in Medicaid payments.
Section G: Electronic Funds Transfer Form and Supporting Documentation
All providers are required to receive payment via secure electronic funds transfer. A voided check for a checking account, a deposit slip for a savings account, or documentation from the provider's banking institution confirming the bank account and routing number must be attached to this application.
Section H: W-9 Tax Information Form
The Tax ID supplied on this form must match that supplied in Field 7 in Section B of the Application. For detailed instructions on completion of the W-9 Form, please reference the IRS Web site at www.irs.gov.
Section I: Health Information Technology (HIT)/Health Information Exchange (HIE) & Electronic Health Record (EHR) Information
This section collects HIT/HIE contact information, and EHR information from providers.
Section J: Additionally Required Documentation
You may be required to submit additional documentation with this application. If you have downloaded this application from the Web portal, or if you are enrolling/re-enrolling on the Web portal, providers can obtain a list of the additional required documentation at www.ctdssmap.com by selecting **Provider**, then **Provider Matrix**, and click on the link titled, "Follow on Document Requirement by Type and Specialty," for a list of the enrollment/re-enrollment requirements document(s) for your provider type/specialty/taxonomy.
Section K: Electronic Signature Policy Compliance
This section addresses the use of electronic signatures on medical records.

Section L: Application Fee Requirement/Attestation
Section 1866(j)(2)(C) of the Affordable Care requires the Connecticut Medical Assistance Program apply an application fee to certain types of providers. These providers are institutional providers of medical or other items or services or supplier (A detailed definition of an "institutional" provider can be found in § 424.502.)

This Federal law generally requires these institutional providers for enrollment and re-enrollment into a Medicaid program to pay an application fee. This fee may also be required when submitting an application to add an alternate service location address(es). This section allows providers to indicate if they have already paid the fee to another state's Medicaid or Children's Health Insurance Program (CHIP) or are in the process of enrolling another state's Medicaid/CHIP program and will pay an application fee to that state. In that case, you are exempt from paying the fee to the Connecticut Medical Assistance Program (CMAP).

Section M: Application Certification and Signature
This section is comprised of a certification page.

Section N: Provider Agreement
Detailed instructions, as well as the agreement itself, can be found in this section.

For **Employed/Contracted by an Organization Practitioners (Performing Provider) as defined above**, please complete the application sections indicated below:

Section A: Type of Enrollment

Section B: Demographic/Provider Specific Information

Section C: Service Location and Facility Information
List primary service location, additional service locations, home office, mail to, pay to, and facility locations. **Note**: A P.O. Box cannot be accepted as any part of the primary service location address. Additionally, the zip +4 extension is a required field on all addresses. To obtain the last 4-digits of the zip code, a provider may access the United States Postal Service Web site at: http://zip4.usps.com/zip4/welcome.jsp.

Section E: Provider Questionnaire
Respond to only questions 1, 2, 3, and 11 in this section. Incomplete or unanswered questions will result in the application to be returned to you for completion.

Section G: Electronic Funds Transfer Form and Supporting Documentation
Non-billing providers participating in the Promoting Interoperability (PI), formerly known as the Electronic Health Records (EHR) incentive program that wish to assign payment to themselves instead of the group/clinic/hospital must complete an EFT form. A voided check for a checking account, a deposit slip for a savings account, or documentation from the provider's banking institution confirming the bank account and routing number must be attached to this application. **This form is not required for all other employed by organization practitioners.**

Section H: W9 Tax Information Form
Only an employed by organization practitioner (member of a group/clinic/hospital) enrolling for the Promoting Interoperability (PI), formerly known as the Electronic Health Records (EHR) incentive program, but wishes to assign payment to him/herself, must complete the W-9 form. The form must contain the taxpayer identification number for you as an individual. For detailed instructions on completion of the W-9 Form, please reference the IRS Web site at www.irs.gov. **This form is not required for all other employed by organization practitioners.**

Section I: Health Information Technology (HIT)/Health Information Exchange (HIE) & Electronic Health Record (EHR) Information
This section collects HIT/HIE contact information, and EHR information from providers.

Section J: Additionally Required Documentation
You may be required to submit additional documentation with this application. If you have downloaded this application from the Web portal, or if you are enrolling/re-enrolling on the Web portal, providers can obtain a list of the additional required documentation at www.ctdssmap.com by selecting Provider, then Provider Matrix, and click on the link titled, "Follow on Document Requirement by Type and Specialty," for a list of the enrollment/re-enrollment requirements document(s) for your provider type/specialty/taxonomy.

Section K: Electronic Signature Policy Compliance
This section addresses the use of electronic signatures on medical records.

Section L: Application Fee Requirement/Attestation
This section is not applicable for Employed/Contracted by an Organization Practitioners

Section M: Application Certification and Signature
This section is comprised of a certification page.

Section N: Provider Agreement
Detailed instructions, as well as the agreement itself, can be found in this section.

Section A and B: Type of Enrollment & Demographic Information

Note: If additional space is needed to complete any of the fields indicated below, please submit on an additional 8 ½ x 11 inch sheet of paper.

Name of Individual Completing Application: _____

Telephone Number: _____

Section A: Please indicate if this application is for a new enrollment, re-enrollment, or the addition of an alternate service location to an already enrolled provider.

☐ **New Enrollment**

☐ **Re-enrollment**

☐ **Addition of Alternate Service Location**

☐ Check here if you are enrolling **solely** for the purpose of payment consideration of Medicare crossover only claims. This means you will only be considered for payment on Medicare crossover claims **ONLY.** If you will be billing for other claims other than Medicare crossover claims, then do **NOT** check this box.

Please check **only one** of the following to identify the type of provider enrollment/re-enrollment being submitted:

☐ Organization Provider

☐ Individual Practitioner

☐ Employed/Contracted by an Organization (Please indicate below the organization(s) of which you are member.)

Organization NPI: _____Organization AVRS ID, if known: _____
Organization NPI: _____Organization AVRS ID, if known: _____
Organization NPI: _____Organization AVRS ID, if known: _____

Section B: Demographic/Provider Specific Information

1. Enrolling Provider Name	
2. Gender*	
3. Date of Birth*	
4. Provider Type	
5. Provider Specialty	
6. Primary Taxonomy**	
7. National Provider Identifier (NPI), if available**	
8. Additional Taxonomy (Supply up to 4)*	
9. Federal Tax ID Number***	

10. Federal Tax ID Effective Date	
11. State Tax ID (Provide number in space on right or check box to indicate no State Tax ID)	☐ _____ ☐ I attest that I do not collect sales tax or do not have employees.
12. License/Certification Number	
13. Clinical Laboratory Improvement Act [CLIA] Number(s)	
14. Medicare Number(s), including CCN	
15. Requested Provider Effective Date	
16. If this application is for a physician assistant, please provide the supervising physician name, NPI, and license number.	Name: _____ NPI: _____ License Number: _____

*Gender and DOB are not required for Organization providers.
**This must match the data on the National Provider Plan and Enumeration System (NPPES).
***For Employed by Organization (performing), this must be your Social Security Number (SSN).

Section C: Service Location and Facility Information

Please complete all that apply. All fields are required.

Primary Service Location: **If your entity has more than one location that sees patients under the billing AVRS ID, please complete the additional service locations below.**		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:		
Contact Phone: (_ _ _) _ _ _ - _ _ _ _	Fax#: (_ _ _) _ _ _ - _ _ _ _	TDD#: (_ _ _) _ _ _ - _ _ _ _
Contact E-mail address:		
Mobile Number: (_ _ _) _ _ _ - _ _ _ _	Pager Number: (_ _ _) _ _ _ - _ _ _ _	Patient Use #: (_ _ _) _ _ _ - _ _ _ _
Handicap Accessible: Y N	Specific Accommodations or Languages Spoken:	

Provider Home Office Location: **If home office is the same as primary service location, leave blank.**		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	

Provider Pay To Location: **If pay to address is the same as primary service location, leave blank.**		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	

Provider Mail To Location: **This location will receive all CT Medical Assistance Program correspondence and payment information, if no Pay To Address is specified.**		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	

Provider Enrollment Address: **This location will receive all enrollment-related communications.**		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	

Section C: Service Location and Facility Information continued

Additional Service Location 1:			
Address 1:		City:	
Address 2:		State:	Zip + 4:
Contact Name:		Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	TDD# (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	
Handicap Accessible: Y N			
Additional Service Location 2:			
Address 1:		City:	
Address 2:		State:	Zip + 4:
Contact Name:		Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	TDD#: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	
Handicap Accessible: Y N			
Additional Service Location 3:			
Address 1:		City:	
Address 2:		State:	Zip + 4:
Contact Name:		Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	TDD#: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	
Handicap Accessible: Y N			
Additional Service Location 4:			
Address 1:		City:	
Address 2:		State:	Zip + 4:
Contact Name:		Contact Phone: (_ _ _) _ _ _ - _ _ _ _	
Fax #: (_ _ _) _ _ _ - _ _ _ _	TDD#: (_ _ _) _ _ _ - _ _ _ _	Contact E-mail address:	
Handicap Accessible: Y N			

Facility Information 1:		
Facility Name:	Facility NPI:	
Address 1:	City:	
Address 2:	State:	Zip + 4: _ _ _ _ _-_ _ _ _
Facility Information 2:		
Facility Name:	Facility NPI:	
Address 1:	City:	
Address 2:	State:	Zip + 4: _ _ _ _ _-_ _ _ _
Facility Information 3:		
Facility Name:	Facility NPI:	
Address 1:	City:	
Address 2:	State:	Zip + 4: _ _ _ _ _-_ _ _ _

Section D: Provider Organization Information Please complete all that apply. All fields are required.

Owners, Partners or Members

Complete the following section for Owners, Partners, or Members (with a 5% or more ownership interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5% or more interest). All fields are required to be completed. Failure to supply will result in a denial of enrollment/re-enrollment. Complete all sections that apply or mark "N/A" on those sections that do not apply. If additional space is needed to complete any of the fields indicated below, please submit on an additional 8 ½ x 11 inch sheet of paper, with your ATN and/or AVRS ID indicated at the top.

Please note, 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.

Owner/Partner/Member 1 Name:			
Address 1:		City:	
Address 2:		State:	Zip:
FEIN:	Social Security Number:		
Percentage of Ownership:	Date of Birth:		
Owner/Partner/Member 2 Name:			
Address 1:		City:	
Address 2:		State:	Zip:
FEIN:	Social Security Number:		
Percentage of Ownership:	Date of Birth:		
Owner/Partner/Member 3 Name:			
Address 1:		City:	
Address 2:		State:	Zip:
FEIN:	Social Security Number:		
Percentage of Ownership:	Date of Birth:		
Owner/Partner/Member 4 Name:			
Address 1:		City:	
Address 2:		State:	Zip:
FEIN:	Social Security Number:		
Percentage of Ownership:	Date of Birth:		

Section D: Provider Organization Information continued

Information About the Corporation
Is this corporation is a subsidiary of another company? YES [ ] NO [ ] If "yes," please provide the following information:
Name of Parent Company:
Corporate Headquarters Location:

Information about Corporate Officers. Please provide the information requested below for all corporate officers. If the applicant corporation is a subsidiary of another company, please provide the information about corporate officers of the applicant and the parent corporations.

Name and Title:		Applicant [ ] Parent [ ]
Address 1:		
Address 2:		
City:	State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:

Name and Title:		Applicant [ ] Parent [ ]
Address 1:		
Address 2:		
City:	State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:

Name and Title:		Applicant [ ] Parent [ ]
Address 1:		
Address 2:		
City:	State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:

Name and Title:		Applicant [ ] Parent [ ]
Address 1:		
Address 2:		
City:	State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:

If additional space is needed, please add on a separate sheet of paper.
Members of Board of Directors

Name and Title:		
Address 1:		
Address 2:		
City:	State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:

Name and Title:		
Address 1:		
Address 2:		
City:	State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:

Section D: Provider Organization Information continued

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:	

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:	

Managing Employees (defined as a general manager or administrator who exercises operational or managerial control over, or who directly or indirectly conducts day-to-day operation of an entity)

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:	

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:	

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:	

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: (_ _ _) _ _ _ - _ _ _ _	Social Security Number:	Date of Birth:	

Section E: Provider Questionnaire

For Organizations and Individual Practitioners, please answer each of the following questions. Employed by Organization providers are only required to answer questions 1, 2, 3, and 11. Blank responses will result in a Return To Provider letter requesting the information be completed. This will delay the processing of this enrollment/re-enrollment packet. If you believe a question is Not Applicable, please select No in the response field.

1. Is, or was, applicant a Medicaid provider in any other state? YES [ ] NO [ ] If "Yes", list:

State:	National Provider Identifier:	Date:
State:	National Provider Identifier:	Date:
State:	National Provider Identifier:	Date:

2. Is applicant a provider for any other federal program, e.g., MEDICARE? YES [ ] NO [ ]
   If "Yes", list the name of the program.

Program Name:	National Provider Identifier:
Program Name:	National Provider Identifier:
Program Name:	National Provider Identifier:

3. Has the applicant ever been denied enrollment in Medicaid, Medicare or any other state or federal program? YES [ ] NO [ ]
   If "Yes," list:

Program Name:	Date of Denial:	Reason for Denial:
Program Name:	Date of Denial:	Reason for Denial:

4. Does applicant contract with any private health insurance providers? YES [ ] NO [ ] If "Yes", list:

Insurance Name:	Contract Number:
Insurance Name:	Contract Number:
Insurance Name:	Contract Number:

5. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family or marriage? YES [ ] NO [ ] If "Yes", identify:

Name:	Date of Birth:	Social Security Number:	Relationship:

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 [ ]
   If "Yes", identify that individual:

Name:	Date of Birth:	Social Security Number:	Relationship:

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 [ ]
   If "Yes", identify:

Name Debtor:	Amount Owed:	To Whom it is Owed:	Reason for Debt:

Section E: Provider Questionnaire continued

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 [ ]
If "Yes", identify:

Date Filed:	Location Filed:	Name Filed Under:	Name of Individual:	Position of Individual with Business

9. Is applicant and/or owner, partner, member, or officer, currently in bankruptcy? YES [ ] NO [ ] If "Yes", identify:

Date Filed:	Location Filed:	Name Filed Under:

10. Does the applicant and/or owner, partner, member or officer have an ownership or control interest in any other provider? YES [ ] NO [ ] If "yes", identify:

Name:

Address:

11. 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 [ ]

If "Yes", please list any and all actions:

12. Is applicant a salaried employee of a hospital, clinic, or institution? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, or institution:

13. Does applicant provide contractual services to a hospital, clinic, or institution? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, or institution:

14. If you are re-enrolling, has there been a change in ownership or control of 5% or greater since your last enrollment? YES [ ] NO [ ]

If "Yes" to the question above, indicate the date of change:
Describe type of ownership change:

15. Are you a contractor for an enrolled Connecticut Medical Assistance Program Provider? YES [ ] NO [ ]

If "Yes", list provider:

16. Are you an employee of an enrolled Connecticut Medical Assistance Program Provider? YES [ ] NO [ ]

If "Yes", list provider:

If you answered Yes to questions 15 or 16, you must complete the following additional questions:

17. Does the provider have an address which is the same as the address of the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

18. Does the provider have a tax ID which is the same as the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

19. Are any of the staff working with the provider, such as nurses, physician assistants, or support staff, shared with or employed by the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

Section E: Provider Questionnaire continued	
20. Does the provider share, or have the use of, any space which belongs to the hospital, institution, group, or clinic (i.e. space which is not leased from the hospital, institution, group, or clinic)?	YES [ ] NO [ ]
If "Yes", name of the hospital, clinic, group, or institution:	
21. Is there a subsidy of any type to or from the hospital, institution, group, or clinic?	YES [ ] NO [ ]
If "Yes", name of the hospital, clinic, group, or institution:	

Section F: False Claims Act Compliance Attestation

This attestation must be completed if your organization, unit, corporation, partnership, or other business arrangement, including any managed care organization, irrespective of form of business structure or arrangement by which it exists, whether for-profit or not-for-profit, which furnishes directly, or otherwise authorizes the furnishing of, the delivery of Medicaid health services where payments made with respect to those services are received, or made, under a State Plan approved under Title XIX, or any waiver of such plan totaling at least $5,000,000 annually.

I, _____ [name of entity's authorized representative**], hereby swear or attest, under the penalty for false statement, that in my capacity as _____ [**position or office held by entity's authorized representative**] of _____ [**name of entity**] have the authority to make this attestation on behalf of _____ [**name of entity**] and have attached appropriate documentation proving that I possess such authority. _____ [**name of entity**] has complied with all applicable requirements of § 1902(a)(68) of the Social Security Act (42 U.S.C. 1396a(a)(68)) and §§ 17b-262-770 through 17b-262-773 of the Regulations of Connecticut State Agencies.**

_____ Date: _____
[Name of entity's authorized representative]

State of _____
County of _____

On this the _____ day of _____, _____, before me, _____, the undersigned officer, personally appeared _____ [name of entity's authorized representative**], who acknowledged herself/himself to be the _____ [**position or office held by entity's authorized representative**] of _____ [**name of entity**], a _____ [**business form of entity, e.g., partnership, corporation, etc.**], and that she/he, as such _____ [**position or office held by entity's authorized representative**], being authorized so to do, executed the foregoing attestation for the purposes therein contained, by signing the name of _____ [**name of entity**] by herself/himself as _____ [**position or office held by entity's authorized representative**], and swore or attested to the truth of the above attestation.**

In witness whereof I hereunto set my hand

_____
Notary Public/Justice of the Peace/ Commissioner of the Superior Court

FALSE STATEMENT IS PUNISHABLE BY A FINE NOT TO EXCEED $2,000.00, IMPRISONMENT FOR NOT MORE THAN ONE YEAR, OR BOTH. CONN. GEN. STAT. § 53a-157b . This attestation must also be provided to the Department's Office of Quality Assurance by August 31st. of each year.

Section G: Electronic Funds Transfer Form (EFT) and Supporting Documentation

Connecticut Medical Assistance Program
Electronic Funds Transfer (EFT) Authorization Agreement

Overview

The Department of Social Services (DSS) requires providers to participate in electronic funds transfer (EFT). Electronic Funds Transfer (EFT) provides for the direct deposit of your payment amount into a bank account of your choosing and is available to Connecticut Medical Assistance Program providers. EFT is a more efficient and cost effective means of reimbursement for Connecticut Medical Assistance Program services.

In order to enroll in EFT, enrolled providers may go to the secure Web site at www.ctdssmap.com by selecting Provider > Secure Site, and enter their user ID and password. If the provider has been granted an exception to submitting this update via the Secure Web portal, the provider may complete the form on the following page.

The information gathered as part of the EFT enrollment process both electronically and on paper are in accordance with the requirements set forth in the Affordable Care Act and the CORE 380 EFT Enrollment Data Rule. Additional information on those requirements can be found on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php. Appendix A of this document provides instructions for completing each of the fields on this form.

Please note: You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the electronic remittance advice ERA. (*Reference Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule Version 3.0.0 available on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php.)*

Timeframe for Completion

The EFT process will take approximately four to six weeks to be completed. Providers will have an initial EFT status of pre-notification, at which time Gainwell Technologies will send a test EFT transaction to the provider's financial institution. During this time, providers will receive a paper check. Providers will remain in this status until a successful pre-notification transaction has been confirmed. Once a successful transaction is made, providers will begin to receive their funds via EFT beginning with the next claims processing cycle. The first time a paper check is not received, providers should confirm with their bank that an EFT has been made.

Verification of EFT Status

A provider can verify their EFT status by contacting the Provider Assistance Center at 1-800-842-8440.

Changes to or Cancellations of EFT Enrollment Information

Providers must inform Gainwell Technologies of any changes to their bank account (i.e. account number, financial institution routing number). Updates to this data should be made at www.ctdssmap.com, by logging on to your Secure Web account. Only providers with approved exceptions may submit this updated "Electronic Funds Transfer Authorization Agreement" form. When EFT changes are made, the changes are subjected to a validation by the financial institution that is listed as the funds destination, before the live transfer of funds is initiated. The provider will be placed in a pre-notification status during this validation period and the provider will once again receive a paper check until a successful pre-notification transaction has been confirmed.

When a provider makes a change to their Electronic Funds Transfer (EFT) information, Gainwell Technologies mails a letter to the provider confirming the change. The letter contains both the previous and the new EFT data. Upon receipt of this letter, providers should confirm that the changes are valid. If a discrepancy exists, the provider should contact the Provider Assistance Center at 1-800-842-8440 immediately.

Providers may also cancel their bank account information after enrollment via their Secure Web portal account. However, since EFT is mandated, providers are required to supply new EFT enrollment information.

Late/Missing EFT Resolution Procedures

If a provider determines that their EFT payment is late or missing, the provider should contact the Provider Assistance Center at 1-800-842-8440.

Contact Information

Any questions on the EFT enrollment process should be directed to the Provider Assistance Center at 1-800-842-8440.

Complete the form below and attach a copy of a voided check for a checking account or documentation from your banking institution confirming the bank account and financial institution routing number that will be utilized for the EFT deposit. For a description of the data to be entered in each field, please refer to Appendix A.

Provider Name:

_____

Provider Identifiers:

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) OR National Provider Identifier (NPI)	_____ _____

Other Identifiers:

Assigning Authority	Medicaid
Trading Partner ID	

Provider Contact Information:

Provider Contact Name	
Telephone Number	
Telephone Number Extension	
Email Address	

Financial Institution Information:

Financial Institution Name	
Financial Institution Routing Number	
Type of Account at Financial Institution	
Provider's Account Number with Financial Institution	
Account Number Linkage to Provider Identifier Provider Tax Identification Number (TIN)	_____

OR National Provider Identifier (NPI)	_____
Reason for Submission	_____New Enrollment _____Change Enrollment _____Cancel Enrollment

I agree to keep, and disclose upon request to authorized agencies, records that disclose fully the extent of payments claimed from the services rendered to clients of the Connecticut Medical Assistance Program. I accept as payment in full the amount paid by the Connecticut Medical Assistance Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Connecticut Medical Assistance Program payments made to the above provider number(s). I understand that I am responsible for the validity of the above information.

Authorized Signature _____

Return this form to:
Gainwell Technologies
P.O. Box 5007
Hartford, CT 06102-5007

Please Note: Connecticut Medical Assistance Program providers who are currently enrolled in EFT are not required to complete this form. Providers must, however, inform Gainwell Technologies of any changes to this information by updating this information at www.ctdssmap.com, or on an approved exception basis, by using this form.

Appendix A – Data Element Descriptions

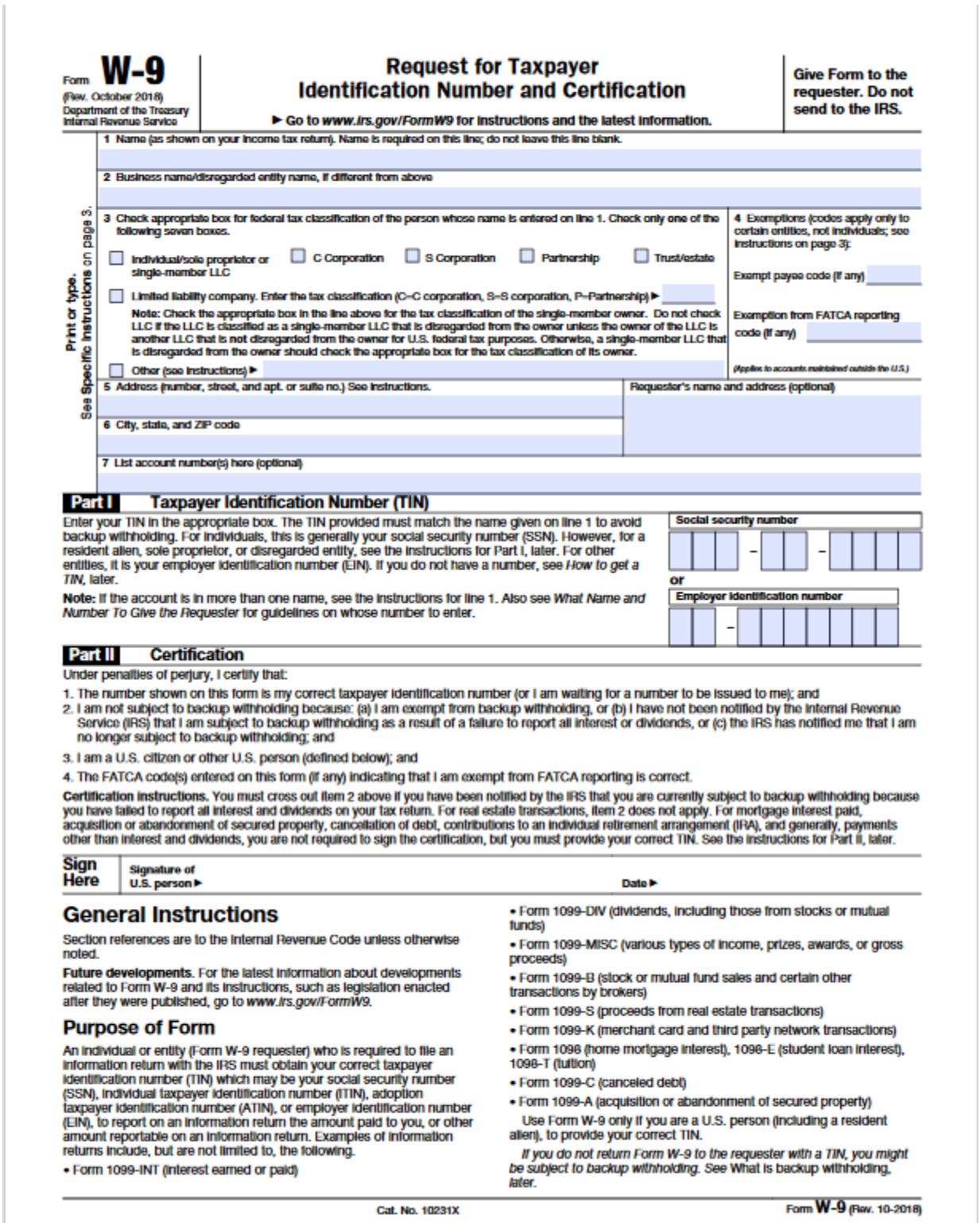
ACA 1104 Phase III Core 380 Enrollment Data Rule Field Name	*ACA 1104 Phase III Core 380 Enrollment Data Rule Field Description*	*Instructions for the Connecticut Medical Assistance Program*
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Enter the provider's name.
Provider Identifiers: Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) - OR – National Provider Identifier (NPI)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Enter the NPI associated to the provider. Only if the provider is atypical and does not have an NPI, enter the provider's TIN/EIN.

ACA 1104 Phase III Core 380 Enrollment Data Rule Field Name	*ACA 1104 Phase III Core 380 Enrollment Data Rule Field Description*	*Instructions for the Connecticut Medical Assistance Program*
Other Identifiers		
Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid	This field displays "Medicaid". No additional data is required in this field.
Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor. For the Connecticut Medical Assistance Program, this is the provider's nine digit AVRS ID.	This field will display the provider's 9-digit AVRS ID, if available and is non-updateable.
Provider Contact Name	Name of a contact in provider office for handling EFT issues	Enter the individual to be contacted for any EFT related issues.
Telephone Number	Associated with contact person	Enter the telephone number associated to that contact.
Telephone Number		Enter the telephone number extension associated to that contact.
Email Address	An electronic mail address at which the health plan might contact the provider	Enter the email address associated to that contact.
Financial Institution Name	Official name of the provider's financial institution	Enter the name of the provider's financial institution.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Enter the 9-digit financial institution routing number where payments are to be deposited.
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Enter the type of account to which the funds will be deposited (checking or savings).
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited	Enter the provider's account number to which EFT payments are to be deposited.
Account Number Linkage to	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12	Enter the provider's preference for grouping claim payments – either by TIN or NPI.

ACA 1104 Phase III Core 380 Enrollment Data Rule Field Name	*ACA 1104 Phase III Core 380 Enrollment Data Rule Field Description*	*Instructions for the Connecticut Medical Assistance Program*
Provider Identifier Provider Tax Identification Number (TIN) National Provider Identifier (NPI)	835 remittance advice	Please note that the account number entered here must match the Preference for Aggregation of Remittance Advice Data to be entered at the time a Trading Partner or provider enrolls for an Electronic Remittance Advice.
Reason for Submission - New Enrollment - Change Enrollment - Cancel Enrollment		Select the reason for submission of the EFT enrollment data. - If the provider is not currently enrolled in EFT, the reason for submission should be New Enrollment. - If the provider is currently enrolled in EFT and wishes to update their EFT information, the reason for submission should be Change Enrollment. - If the provider is currently enrolled in EFT and wishes to cancel that enrollment, the reason for submission should be Cancel Enrollment. Please note, however, that EFT is mandated by DSS. If the provider cancels their current enrollment, they must submit new EFT enrollment data.
Include with Enrollment Submission Voided Check Bank Letter	 A voided check is attached to provide confirmation of Identification/Account Numbers A letter on bank letterhead that formally certifies the account owners routing and account numbers	Attach a copy of a voided check or bank letter when enrolling or updating EFT information using this paper form.
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment	Enter the name of the individual authorized by the provider to initiate, modify, or terminate an enrollment.

Section H: W-9 Tax Information Form

For detailed instructions on completion of the W9 Form, please reference the IRS Web site at www.irs.gov .



Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ► Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

Section I: Health Information Technology (HIT)/Health Information Exchange (HIE) & Electronic Health Record (EHR) Information & Questionnaire

HIT/HIE Contact Information	
Contact First Name:	Contact Last Name:
Contact Phone: (_ _ _) _ _ _ - _ _ _ _	Phone Ext:
Contact E-mail address:	

Question 1 is required to be answered. If the answer to question 1 is, "Yes," then questions 2 – 7 are required.
1. Do you use an Electronic Health Record system? YES [ ] NO [ ]
2. Does that system meet the most current CMS/ONC Federal certification standards? YES [ ] NO [ ]
3. If you use an EHR, which system are you using?
4. Is your EHR able to generate Continuity of Care Documents (CCD)? YES [ ] NO [ ]
5. Is your EHR able to generate Consolidated-Clinical Document Architecture (C-CDA)? YES [ ] NO [ ]
6. Is your EHR able to generate Quality Reporting Document Architecture (QRDA)? YES [ ] NO [ ]
7. Direct Mailbox E-mail address:

Section J: Additionally Required Documentation

You may be required to submit additional documentation with this application. If the provider application has been mailed to you, a list of the additionally required documentation and any other necessary forms have been attached. If you have downloaded this application from the Web portal, providers can obtain a list of the additional required documentation at www.ctdssmap.com by selecting Provider, then Provider Matrix. Once on this page, click on the link titled, "Follow on Document Requirement by Type and Specialty," for a list of the enrollment/re-enrollment requirements document(s) for your provider type/specialty/taxonomy.

Section K: Electronic Signature Policy Compliance

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.

The Provider who uses electronic signatures based upon use of identification codes in combination with passwords, as described above, shall use the following additional controls to ensure the security and integrity of each User's electronic signature:

(a) Ensure that no two Users have the same combination of identification components (such as identification code and password);

(b) Ensure that passwords are revised periodically, and no less often than every 60 days, except as otherwise agreed to in writing by DSS;

(c) Follow loss management procedures to electronically de-authorize lost, stolen, missing or otherwise compromised documents or devices that bear or generate identification code or password information and use suitable, rigorous controls to issue temporary or permanent replacements;

(d) Use safeguards to prevent the unauthorized use or attempted use of passwords and/or identification codes; and

Section K: Electronic Signature Policy Compliance continued

(e) Test or use only tested devices, such as tokens or cards that bear or generate identification code or password information to ensure that they function properly and have not been altered.

If a Provider uses electronic signatures based on two (2) components that are other than identification codes in combination with passwords, the Provider shall use the additional controls as set forth in (a) through (e) of this paragraph as applicable to those identification components.

Providers must use a secure, computer-generated, time-stamped audit trail that records independently the date and time of User entries, including actions that create, modify or delete electronic records. Record changes shall not obscure previously recorded information. Audit trail documentation shall be retained for a period at least as long as that required for the medical record and shall be available to DSS for review and copying.

Section L: Application Fee Requirement/Attestation

Required fields are indicated with an asterisk (*)

About the Application Fee

- Federal law generally requires some applicants for enrollment and re-enrollment into a Medicaid program to pay an application fee.
- Based on the provider type/specialty in which a provider is enrolling/re-enrolling, you may be subject to an application fee. Providers will be notified upon submission of their application via a letter if an application fee is due.
- The may change from year to year based on adjustments to the Consumer Price Index for Urban Areas.
- If you have paid the fee to another state's Medicaid or Children's Health Insurance Program (CHIP) or are in the process of enrolling another state's Medicaid/CHIP program and will pay an application fee to that state, you are exempt from paying the fee to the Connecticut Medical Assistance Program (CMAP).
- The Fee is nonrefundable. If a provider applicant does not meet participatory requirements or does not submit the appropriate documentation within the time frame requested, the fee will not be refunded. Any subsequent submissions of an application for enrollment or re-enrollment to CMAP would require payment of a new application fee.

To assist in determining if a fee is due for this application, please complete the CMAP Attestation Fee Payment below.

Attestation of Application Fee Payment

I am currently enrolled in, or in the process of enrolling in another state's Medicaid or Children's Health Insurance Program (CHIP) with the same tax ID and provider type and have paid an application fee or will be paying an application fee for the service location(s) that will be listed on this application to that state's Medicaid or CHIP Program.

Please choose one of the following fields *: ☐Yes ☐No

If you answered, YES, please complete all fields below:

State to which the application fee was paid/will be paid*: _____

Date paid/to be paid*: _____

Contact name*: _____

Contact phone number*: _____ Ext.: _____

Check Number or Tracking ID: _____

Provide any additional reference or tracking information associated with the Medicaid program to which you paid the fee. If additional space is needed, please continue on the next page:

Section L: Application Fee Requirement/Attestation

Based on the information above, your application will be reviewed for fee payment. If it is determined that an application fee is due, you will be notified via letter. The letter will specify the fee amount and will provide instructions on how to submit that fee. Please do not submit a fee unless you are informed that one is due.

Section M: Application Certification and Signature

CERTIFICATION

If I use electronic signatures, I certify that the provider's policies meet the DSS requirements for acceptance, issuance, and use of electronic signatures set forth in Section K above.

I further 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.

(The person signing this certification must be the same person whose signature appears on the Provider Agreement.)

_____ _____

Date Signature

_____

Name (please print)

_____

Date of Birth

_____

Social Security Number

_____

Title

Section N: Provider Agreement

Instructions for the completion of the provider agreement can be found on the table below. The provider agreement follows these instructions.

Please Note: If you are a Long Term Care (with the exception of a Chronic Disease Hospital), Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID), Connecticut Home Care (CHC) Service Provider, Acquired Brain Injury, Autism Service, Mental Health Waiver (MHW), School Based Child Health (SBCH), CT Housing Engagement and Support Services (CHESS), or a Community First Choice (CFC) Support and Planning Coach provider, there is an addendum to the standard provider agreement that you must also review. The appropriate addendum can be found on the www.ctdssmap.com Web portal, by selecting Information > Publications, scrolling down to the Provider Enrollment/Maintenance Forms section, and selecting the link for the appropriate agreement.

Field on Application	Type of Provider	Instructions for Completion
Name of Applicant field (located on first page of application)	▪ Organization ▪ Individual Practitioner ▪ Employed/Contracted by an Organization ▪ Organization that is Employed/Contracted by Another Organization	Must contain the provider's legal name and must match the name indicated in Section B, Field 1 of the Demographic/Provider Specific Information form.
Provider Entity Name field (located on the final page of the agreement)	▪ Organization ▪ Individual Practitioner ▪ Organization that is Employed/Contracted by Another Organization	Must contain the organization's or individual practitioner's name. If you are doing business under another name, it is permissible to put that information after the organization's or individual practitioner's name.
	▪ Employed/Contracted by an Organization	Must contain the individual's name.
Name of Authorized Representative field (located on the final page of the agreement)	▪ Organization ▪ Individual Practitioner ▪ Organization that is Employed/Contracted by Another Organization	For an individual practitioner, must contain the printed name of the provider or the authorized representative in the first field. For group/clinic providers, this must be the person that is authorized to sign for the group/clinic.
	• Employed/Contracted by an Organization	Must contain the printed name of the individual employed by the organization or an authorized representative.
Signature of Authorized Representative field (located on the final page of the agreement)	▪ Organization ▪ Individual Practitioner ▪ Organization that is Employed/Contracted by Another Organization	For an individual practitioner, must contain the signature of the provider or the authorized representative. In the instance of an organization, this must be the person that is authorized to sign for that organization.
	• Employed/Contracted by an Organization	Must contain the signature of the individual employed by the organization or an authorized representative.

Section N: Provider Agreement continued

S T A T E O F C O N N E C T I C U T
DEPARTMENT OF SOCIAL SERVICES
Medical Care Administration
Provider Enrollment Agreement

_____,

(Name of Applicant)

(hereinafter the "Provider") wishes to participate in the Connecticut Medical Assistance Program. For purposes of this Provider Enrollment Agreement (hereinafter the "Agreement"), the term "Connecticut Medical Assistance Program" means any and all of the health benefit programs administered by the State of Connecticut Department of Social Services (hereinafter "DSS"). The Provider represents and agrees as follows:

General Provider Requirements

1. To comply continually with all enrollment requirements established under rules adopted by DSS or any successor agency, as they may be amended from time to time.
2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.
3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable.
4. To furnish all information requested by DSS specified in the Provider Enrollment Agreement and the Application Form, and, further, to notify DSS or its designated agent, in writing, of all material and/or substantial changes in information contained on the Application Form.

   To furnish material and/or substantial changes in information including changes in the status of Medicare, Medicaid, or other Connecticut Medical Assistance program eligibility, provider's license, certification, or permit to provide services in/for the State of Connecticut, and any change in the status of ownership of the Provider, if applicable.
5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.
6. To maintain a specific record for each client eligible for the Connecticut Medical Assistance Program benefits, including but not limited to name; address; birth date; Social Security Number; DSS identification number; pertinent diagnostic information including x-rays; current treatment plan; treatment notes; documentation of dates of services and services provided; and all other information required by state and federal law.
7. To maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law governing record retention, whichever period is greater. In the event of a dispute concerning goods and services provided to a client, or in the event of a dispute concerning reimbursement, documentation shall be maintained until the dispute is completely resolved or for five years, whichever is greater.

   The Provider acknowledges that failure to maintain all required documentation may result in the disallowance and recovery by DSS of any amounts paid to the Provider for which the required documentation is not maintained and provided to DSS upon request.

8. To maintain, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-8, inclusive, and regulations promulgated thereto, as they may be amended from time to time, the confidentiality of a client's record, including, but not limited to:
   a. client's name, address, and Social Security number;
   b. medical services provided;
   c. medical data, including diagnosis and past medical history;
   d. any information received for verifying income eligibility; and
   e. any information received in connection with the identification of legally liable third party resources.

   Disclosure of clients' personal, financial, and medical information may be made under the following circumstances:
   f. to other providers in connection with their treatment of the client;
   g. to DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;
   h. in connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of or billing for services covered by the Connecticut Medical Assistance Program;
   i. as required to obtain reimbursement from other payer sources;
   j. as otherwise required by state or federal law; and
   k. with the client's written consent to other persons or entities designated by the client or legal guardian, or, in the event that the client is a minor, from the client's parents or legal guardian.

   Upon request, disclosure of all records relating to services provided and payments claimed must be made to the Secretary of Health and Human Services; to DSS; and/or to the State Medicaid fraud control unit, in accordance with applicable state and federal law.

   In the event that the Provider authorizes a third party to act on the Provider's behalf, the Provider shall submit written verification of such authorization to DSS.

9. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract, and, in accordance with 42 C.F.R. § 455.105 and § 431.115 et seq., to provide upon request of the Secretary of Health and Human Services and/or DSS, full and complete information about the ownership of any subcontractor or any significant business transaction.

   No subcontract, however, terminates the legal responsibility of the Provider to DSS to assure that all activities under the contract are carried out. Provider shall furnish to DSS upon request copies of all subcontracts in which monies covered by this Agreement are to be used. Further, all such subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of this Agreement.

10. To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted. Receipt of amendments, bulletins and notices by Provider shall be presumed when the amendments, bulletins, and notices are mailed or emailed to the Provider's current address or email address that is on file with DSS or its fiscal agent, or posted to the Connecticut Medical Assistance Program web site.

11. To make timely efforts to determine clients' eligibility, including verification of third-party payor resources, and to pursue insurance, Medicare and any other third party payor prior to submitting claims to the Connecticut Medical Assistance Program for payment.

    Provider further acknowledges the Connecticut Medical Assistance Program as payor of last resort. Provider agrees to exhaust clients' medical insurance resources prior to submitting claims for reimbursement and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

12. To comply with the advance directives requirements set forth specified in 42 C.F.R. Part 489, Subpart I, and 42 C.F.R. § 417.436(d), if applicable.

Billing/Payment Rates

13. To submit timely billing in a form and manner approved by DSS, as outlined in the Provider manual, after first ascertaining whether any other insurance resources may be liable for any or all of the cost of the services rendered and seeking reimbursement from such resource(s).

14. To comply with the prohibition against reassignment of provider claims set forth in 42 C.F.R. § 447.10.

15. To submit only those claims for goods and services that are covered by the Connecticut Medical Assistance Program and that are documented by Provider as being:
    a. for medically necessary goods and services;
    b. for medically necessary goods and services actually provided to the person in whose name the claim is being made;
    c. for compensation that Provider is legally entitled to receive; and
    d. in compliance with DSS requirements regarding timely filing.

16. To accept payment as determined by DSS or its fiscal agent in accordance with federal and state statutes and regulations and policies as payment in full for all services, goods, and products covered by Connecticut Medical Assistance Program and provided to program clients. The Provider agrees not to bill program clients for services that are incidental to covered services, including but not limited to, copying medical records and completing school and camp forms and other forms relating to clients' participation in sports and other activities. The Provider further agrees not to bill clients or any other party for any additional or make-up charge for services covered by the Connecticut Medical Assistance Program, excluding any cost sharing, as defined in section 17b-290(6) of the Connecticut General, and as permitted by law, even when the Program does not pay for those covered services for technical reasons, such as a claim not timely filed or a client being managed-care eligible, or a billed amount exceeding the program allowed amount. The provider may charge an eligible Connecticut Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services that are not covered under the Connecticut Medical Assistance Program, only when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them.

    The Provider shall refund to the payor any payment made by or on behalf of a client determined to be eligible for the Connecticut Medical Assistance Program to the extent that eligibility under the program overlaps the period for which payment was made and to the extent that the goods and services are covered by Connecticut Medical Assistance Program benefits.

17. To timely submit all financial information required under federal and state law.

18. To refund promptly (within 30 days of receipt) to DSS or its fiscal agent any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements.

19. To make repayments to DSS or its fiscal agent, or arrange to have future payments from the DSS program(s) withheld, within 30 days of receipt of notice from DSS or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made. This obligation includes repayment of an overpayment received for prior years or pursuant to prior provider agreements. The Provider is liable for any costs incurred by DSS in recouping any overpayment.

20. To promptly make full reimbursement to DSS or its fiscal agent of any federal disallowance incurred by DSS when such disallowance relates to payments previously made to Provider under the Connecticut Medical Assistance Program, including payments made for prior years or pursuant to prior provider agreements.

21. To maintain fiscal, medical and programmatic records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information, including, but not limited to, records and information regarding payments claimed by the Provider for furnishing goods and services, will be made available to authorized representatives upon request, in accordance with all state and federal statutes and regulations.

22. To cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS

payments made to Provider, to ensure the proper administration of the Connecticut Medical Assistance Program and to assure Provider's compliance with all applicable statutes and regulations and policies. Such records and information are specified in federal and state statutes and regulations and the Provider Manual and shall include, without necessarily being limited to, the following:

a. medical records;

b. original prescriptions for and records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Connecticut Medical Assistance Program, including the authority for and the date of administration of such treatment, drugs, or services;

c. any original documentation determined by DSS or its representative to be necessary to fully disclose and document the medical necessity of and extent of goods or services provided to clients receiving assistance under the provisions of the Connecticut Medical Assistance Program;

d. any other original documentation in each client's record which will enable the DSS or its agent to verify that each charge is due and proper;

e. financial records maintained in accordance with generally accepted accounting principles, unless another form is specified by DSS; and

f. all other records as may be found necessary by DSS or its agent in determining Provider's compliance with any federal or state law, rule, regulation, or policy.

23. That any payment, or part thereof, for Connecticut Medical Assistance Program goods or services, which represent an excess over the appropriate payment, or any payment owed to DSS because of a violation due to abuse or fraud, shall be immediately paid to DSS. Any sum not so repaid may be recovered by DSS in accordance with the provisions below or in an action by DSS brought against the Provider.

24. To pay any applicable application fee, as required under federal law.

Audits and Recoupment

25. That in addition to the above provisions regarding billing and payment, Provider agrees that:

a. amounts paid to Provider by DSS shall be subject to review and adjustment upon audit or due to other acquired information or as may otherwise be required by law;

b. whenever DSS makes a determination, which results in the Provider being indebted to the DSS for past overpayments, DSS may recoup said overpayments as soon as possible from the DSS's current and future payments to the Provider. DSS's authority to recoup overpayments includes recoupment of overpayments made for prior years or pursuant to prior provider agreements. A recomputation based upon such adjustments shall be made retroactive to the applicable period;

c. in a recoupment situation, DSS may determine a recoupment schedule of amounts to be recouped from Provider's payments after consideration of the following factors:

(1) the amount of the indebtedness;

(2) the objective of completion of total recoupment of past overpayments as soon as possible;

(3) the cash flow of the Provider; and

(4) any other factors brought to the attention of DSS by the Provider relative to Provider's ability to function during and after recoupment;

d. whenever Provider has received past overpayments, the DSS may recoup the amount of such overpayments from the current and future payments to Provider regardless of any intervening change in ownership;

e. if Provider owes money to DSS, including money owed for prior years or pursuant to prior provider agreements, DSS or its fiscal agent may offset against such indebtedness any liability to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to DSS was incurred. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this

subsection shall apply notwithstanding the form of business organizations utilized by such persons e.g. separate corporations, limited partnerships, etc.; and

f. DSS's decision to exercise, or decision not to exercise, its right of recoupment shall be in addition to, and not in lieu of, any other means or right of recovery the DSS may have.

Fraud and Abuse; Penalties

26. To cease any conduct that DSS or its representative deems to be abusive of the Connecticut Medical Assistance Program and to promptly correct any deficiencies in Provider's operations upon request by DSS or its fiscal agent.

27. To comply with state and federal law, including, but not limited to, sections 1128, 1128A, 1128B, and 1909 of the Social Security Act (hereinafter the "Act") (42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7b,1396h) and Connecticut General Statutes sections 17b-301a to 17b-301p, inclusive, which provide state and federal penalties for violations connected with the Connecticut Medical Assistance Program.

    Provider acknowledges and understands that the prohibitions set forth in state and federal law include, but are not limited to, the following:

    a. false statements, claims, misrepresentation, concealment, failure to disclose and conversion of benefits;
    b. any giving or seeking of kickbacks, rebates, or similar remuneration;
    c. charging or receiving reimbursement in excess of that provided by the State; and
    d. false statements or misrepresentation in order to qualify as a provider.

28. That termination from participation in the Connecticut Medical Assistance Program will result if the Provider is terminated on or after January 1, 2011 under Title XVIII of the Act (Medicare) or any other state's Title XIX (Medicaid) program or Title XXI (CHIP); is convicted of a criminal offense related to that person's involvement with Medicare, Medicaid or Title XXI programs in the last ten years; or if the Provider fails to submit timely and accurate information and cooperate with any screening methods required by law.

29. That suspension may result if the Provider is sanctioned by DSS for having engaged in fraudulent or abusive program practices or conduct, as set forth in state or federal law.

30. That, in accordance with federal law, DSS must temporarily suspend all Medicaid payments to a Provider after it determines there is a credible allegation of fraud for which an investigation is pending, unless DSS has good cause to not suspend payments or to suspend only in part.

31. To comply with the provisions of section 1902(a)(68) of the Act (42 U.S.C. § 1396a(a)(68)) and sections 17b-262-770 to17b-262-773, inclusive, of the Regulations of Connecticut State Agencies, as they may be amended from time to time.

Nondiscrimination

32. To abstain from discrimination or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, sexual orientation, mental retardation, mental or physical disability, including, but not limited to, blindness or payor source, in accordance with the laws of the United States or the State of Connecticut.

    Provider further agrees to comply with:

    a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;
    b. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq., (hereafter the "Rehabilitation Act") as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of the Rehabilitation Act and the regulations, no otherwise qualified handicapped individual in the United States

shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

c. Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et seq., as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulations, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any educational program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services; and

d. the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

Termination

33. That this Agreement may be voluntarily terminated as follows:
    a. by DSS or its fiscal agent upon 30 days written notice;
    b. by DSS or its fiscal agent upon notice for Provider's breach of any provision of this Agreement as determined by DSS; or
    c. by Provider, upon 30 days written notice, subject to any requirements set forth in federal and state law. Compliance with any such requirements is a condition precedent to termination.

Disclosure Requirements

34. To comply with all requirements, set forth in 42 C.F.R. §§ 455.100 to 455.106, inclusive, as they may be amended from time to time. These requirements include, but are not limited to, the full disclosure of the following information upon request:

    a. the name, address, social security number and date of birth of any provider or any individual or managing employee (or tax identification number in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more;

    b. whether any such person is related to another as spouse parent, child, or sibling;

    c. the name of any other disclosing entity in which such a person also has an ownership or control interest;

    d. the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request;

    e. any significant business transactions between Provider and any subcontractor during the 5-year period ending on the date of the request;

    f. the name of any person having an ownership or control interest in Provider, or as an agent or managing employee of Provider, who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or other Connecticut Medical Assistance Programs since the inception of these programs; and

    g. any other information requested in the Provider Enrollment application.

    Provider further agrees to furnish, without a specific request by DSS, the information referenced above at the time of Provider's certification survey, as applicable, and also, without a specific request, disclose the identity of any person with ownership or control interest who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs prior to entering into or renewing this Agreement in accordance with 42 C.F.R. Part 455.

35. That the following penalties, as set forth in 42 C.F.R. §§455.104 to 455.106, inclusive, are applicable to Providers failing to make that section's required disclosures:
    a. DSS will not approve an Agreement and must terminate an existing Agreement if the Provider fails to disclose ownership or control information;
    b. DSS may refuse to enter into or renew an Agreement with a Provider if any person with ownership or interest control, or who is an agent or a managing employee of the provider, has been convicted of a

criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program;

c. DSS may refuse to enter into or terminate an Agreement if it determines that a Provider did not fully and accurately make the required disclosures concerning such convictions.

Miscellaneous

36. That the Agreement, upon execution, supersedes and replaces any Agreement previously executed by the Provider. This Agreement does not impair Provider's obligation to repay to DSS any money owed to DSS pursuant to prior Agreements or the ability of DSS to recoup such amounts from payments made pursuant to this Agreement.
37. The Provider acknowledges that there is no right to renew this Agreement.
38. The Provider will examine publicly available data, including but not limited to the U.S. Department of Health and Human Services Office of Inspector General (hereinafter "OIG"), or any successor agency's, List of Excluded Individuals/Entities Report and the OIG Web site, to determine whether any potential or current employees, contractors or suppliers have been suspended or excluded or terminated from any healthcare program and shall comply with, and give effect to, any such suspension, exclusion, or termination or accordance with the requirements of state and federal law. The Provider shall search the HHS-OIG Web site on a monthly basis, or at such intervals as specified by the OIG or DSS, to capture sanctions that have occurred since the Provider's last search. The Provider shall also routinely search the Administrative Actions List on the DSS website. The Provider shall immediately report to the OIG and to DSS any sanction information discovered in its search and report what action has been taken to ensure compliance with state and federal law. The Provider shall be subject to civil monetary penalties if it employs or enters into contracts with excluded individuals or entities.
39. If the provider uses electronic signatures, the provider certifies that the provider's policies meet the DSS requirements for acceptance, issuance, and use of electronic signatures.

The effective date of this Agreement and the period of time during which this Agreement shall be in effect, unless terminated by either party prior to the stated ending date, shall be written on the letter DSS sends to the Provider, through its Fiscal Agent Contractor, approving the Provider for participation in the Connecticut Medical Assistance Program. This approval letter shall be incorporated into and made part of this Agreement. If the Provider fails to complete an application for re-enrollment by the time the current Agreement has expired, DSS may stop making payments to the Provider, although DSS will retroactively make payments for services provided under the Connecticut Medical Assistance Program for up to six months from the date the re-enrollment was due.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

_____

Provider Entity Name (doing business as)

_____

Name of Provider or Authorized Representative (type/print name)

_____

Signature of Provider or Authorized Representative