Connecticut interChange MMIS

Provider Manual

Chapter 3 - Enrollment Re-enrollment

April 16, 2025

Connecticut Department of Social Services (DSS)
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Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	01/01/2008	Initial Release.	All	All
1.1	07/10/2009	Updated type/specialty descriptions, removed the town type, and added MH Waiver and Hospice provider types; added Charter Oak program, clarified enrollment/re-enrollment instructions, misc. other updates.	3.1 3.2 3.3 3.4 3.5 3.6 3.7	2 4 6-11, 13-14 16-18, 23-24 28-29, 31- 33 35-36 38
1.2	02/11/2010	Add new dental types/specialties, updated description for DDS waiver, updated re-enrollment periods for Access Agencies and their performers.	3.4	17-18, 21-22
1.3	07/28/2010	Added new specialty for CHC PCA Waiver; updated to reflect discontinuation of SAGA program and the implementation of the Medicaid Low Income Adults program; removed references to an ID/password requirement to access Chapter 10, added TDD/TTY number.	3.1 3.2 3.3 3.4 3.5 3.6 3.7	2 4 7-11, 15 18, 22 27-30, 33 37 39
1.4	03/15/2011	Add new specialty for Intermediate Duration Acute Psychiatric Care Hospital, added instructions for obtaining an application's status, added reference to performers within an FQHC Clinic.	3.3 3.4 3.5 3.6	11, 14-15 17 34 36
1.5	06/20/2011	Added new type/specialty for Employment and Day Supports waiver, removed dental specialty for nurse practitioners, removed references to SAGA, added more references to Chapter 10, added	3.1 3.3 3.4	2 6-9 18-19

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Version	Version Date	Reason for Revision	Section	Page(s)
		detailed information on retroactive enrollment date requests.	3.5 3.7	27, 29 38
1.6	11/29/2011	Added new types/specialties for physicians, APRNs, physician assistants, occupational therapists, and enhanced care clinics.	3.4 3.5	16-26 31
1.7	03/29/2012	Updates made as a result of new Web portal and new enrollment requirements.	All	All
1.8	07/10/2012	Updates made as a result of additional provider types/specialties in new Web portal, as well as the implementation of NEMT and other misc. updates.	3.1 3.2 3.3 3.4 3.5 3.6	2-4 8-14 16, 17, 26 31 34-35 38
1.9	03/14/2013	Removed NEMT specialties not currently used and incorporated miscellaneous other updates.	3.1 3.2 3.3 3.5	4 8-10 15, 17, 25, 26 33-35
2.0	04/19/2013	Added CHC and Autism Waiver specialties, updated OOS Enrollment procedures.	3.2 3.3 3.4	4 18 31-32
2.1	06/03/2013	Updated to reflect specialty to be used for Autism Waiver performing providers, added new verification process against SSA, added reference to ordering/prescribing/referring provider application.	3.1 3.2 3.3 3.5	3 11-12 18 34
2.2	11/19/2013	Updated to reflect shutdown of ConnPACE and Charter Oak programs. Included instructions for accessing list of OPR providers.	All	All
2.3	03/31/2014	Updated to add new specialties for Early Childhood Autism Waiver program, as well as FQHCs.	3.1 3.3 3.5	2-3 19, 25 35

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Version	Version Date	Reason for Revision	Section	Page(s)
2.4	05/29/2014	Updated to add new resident type/specialties.	3.3	28
2.5	01/01/2015	Updated to add new ABI II Waiver specialty and new types/specialty for Autism Spectrum Disorder. Updated to include Optical Shops with Optician Groups. Removed references to Charter Oak and ConnPACE. Updated re-enrollment requirements/timeframes.	3.1 3.2 3.3 3.4 3.5	2 9-10,12-14 18-19, 25, 29 33 37-38
2.6	03/26/2015	Updated to reflect Web portal enrollment for SBCH providers. Added additional level of detail on member enrollment restrictions.	3.1 3.2 3.3 3.5	2 2-6 13-14 18 37
2.7	06/25/2015	Updated to reflect Web portal enrollment for LTC providers. Added new Community First Choice, Resident Podiatry, and State Institution PRTF type/specialties. Revised due date for annual PRTF letters. Added additional restriction information for therapists in clinics and hospitals and removed Audiologists. Added reference to maintaining email subscriptions. Replaced references to Mental Health Clinic/FQHC with Behavioral Health Clinic/FQHC.	All	All
2.8	11/01/2015	Updated to replace HP references/logo with DXC Technology references/logo.	All	All
2.9	04/25/2016	Add re-enrollment periods for new provider hospital, ABI, PCA, and TCM specialties. Revised/added description for DMHAS and DDS billing and performing providers. Updated to reflect optometrists can be enrolled under Medical FQHC.	3.1 3.2 3.3 3.4	3, 5, 6 10 19-21, 25-26 33
3.0	10/21/2016	Misc updates.	3.1 3.3	2-3, 5, 7 27
3.1	03/20/2017	Updated specialty descriptions for behavioral health clinicians. Updated to reflect new Birth to Three enrollment/re-enrollment requirements, and to include new School Based Health Center	3.1 3.2 3.3	3, 7 15

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Version	Version Date	Reason for Revision	Section	Page(s)
		provider specialty. Updated zip code for PO Box 5007.	3.5	21, 28, 30 40
3.2	09/12/2017	Updated as a result of Autism Waiver program changes. Also updated as a result of enrollment of performing providers under State Institutions. Misc other updates.	3.1 3.2 3.3	5-7 14-15 22, 26
3.3	01/29/2018	Added Transportation Broker. Updated specialty descriptions for hospital and long-term care provider specialties. Updated list of provider types/specialties that enroll on paper.	3.1 3.3	7 20-21, 30
3.4	04/03/2018	Added instructions for submitting an application when provider adding an alternate service location address. Misc other updates.	All	All
3.5	04/30/2017	Replaced section on what type/specialties could be enrolled under a group/clinic/organization with a link to a document on the provider Web portal. Updated procedures to submit add alternate service location address.	3.1 3.5	All 23-24
3.6	11/01/2018	Updated to reflect changes in CADAP program administration.	3.2 3.4	7, 18
3.7	05/16/2019	Updated to remove Mental Health Waiver as a paper enrollment/re-enrollment exception. Updated to add VIN validation for ambulance providers.	3.1 3.5	4 22
3.8	07/17/2019	Removed all provider type specific paper application exceptions.	3.1 3.2	4 8, 10-12
3.9	09/29/2020	Added Adverse Action file to description of periodic checks performed by DSS	3.5	22
4.0	10/01/2020	Updated to replace DXC Technology references/logo with Gainwell Technologies references/logo.	All	All
4.1	12/20/2021	Misc updates to links used throughout chapter.	All	All

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Version	Version Date	Reason for Revision	Section	Page(s)
4.2	4/16/2024	Updated and added links to Provider Manual chapters throughout manual	All	All
		Added reference to application fees.	3.1 3.2	3-4 11,18
		Updated Magellan to Prime Therapeutics Management LLC for the PBM who became the new PBM effective	3.2 3.4	9 45
		Added enrollment/re-enrollment checklist.	3.2	11
		Added step-by-step online enrollment information to section 3.2	3.2	10-34
		Added information regarding Provider Enrollment Tracking	3.2	37-42
		Removed information regarding submission of paper enrollment application	3.2	35
		Added additional information to section 3.3	3.3	41
		Added section 3.6 Provider Ownership Changes	3.6	59-61

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3.1 Overview

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Enrollment/Re-enrollment Responsibilities

Overview	In order to receive reimbursement for services rendered to Connecticut Medical Assistance Program clients, providers must be enrolled in the program. Additionally, to remain active in the Connecticut Medical Assistance Program, providers are required to periodically re-enroll. The Department of Social Services (DSS) offers providers online tools for both enrollment and re-enrollment, which are further described below. This chapter also provides detailed information on the frequency of a provider's re-enrollment. Providers may refer to Chapter 2 - Provider Participation Policy for more information on provider participation and enrollment.
Taxonomy/Type/Specialty	During the enrollment/re-enrollment process, the provider indicates the appropriate taxonomy/provider type/specialty. This information determines the services for which that provider can bill. Providers should be sure they enroll in the appropriate taxonomy/provider type/specialty to ensure accurate billing and reimbursement rates. Please consult the fee schedules prior to enrolling at the www.ctdssmap.com Web site. Please see the Type/Specialty/Taxonomy crosswalk located at www.ctdssmap.com under Information and then Publications and scroll down to the Provider Enrollment/Maintenance Forms section to obtain the list of valid taxonomies/provider types/provider specialties.
Organization Provider	The Department of Social Services classifies providers as follows: An organization provider consists of one or more performers or members, such as a hospital, physician group, dental group, clinic, or state contracted access agency. The organization would be the billing provider.
Individual Provider (Solo Practitioner)	An individual practitioner provider would be a single individual or entity and is considered the biller and performer of service. Example includes a single physician office practice.
Employed/Contracted by an Organization Provider (Performing Provider)	A member of a provider group/clinic/hospital outpatient clinic/FQHC/waiver program would be a performing provider. A performing provider can be either an individual or an organization. The provider group/clinic/hospital outpatient clinic/FQHC/waiver program would bill for the services provided by the member/performer of the group/clinic/hospital outpatient clinic/FQHC/waiver program. Each member of a provider group/clinic/hospital outpatient clinic/FQHC/waiver program needs to enroll/re-enroll and indicate the group/clinic/hospital outpatient clinic/FQHC/waiver program that they are a member of at this time.

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	To determine which provider type(s) and or specialty(s) are allowed enrollment under a provider group/clinic/hospital outpatient clinic/FQHC/waiver program, providers can access the following document located on the www.ctdssmap.com Web site under Information > Publications > Forms > Provider Enrollment/Maintenance Forms or by selecting the link below: Group Type to Individual Type Crosswalk When a member enrolls or a group/clinic/hospital outpatient clinic/FQHC/waiver program associates a member to their group/clinic/hospital outpatient clinic/FQHC/waiver program, these restrictions are enforced via the Wizard or the Secure Web portal.
Ordering /Prescribing/Referring Provider (OPR)	An ordering/prescribing/referring provider is defined as one who prescribes, refers or order 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. DSS will deny a claim if the ordering/prescribing/referring (OPR) provider submitted on a claim is not enrolled in CMAP. Providers may refer to Chapter 10 – Web Portal / AVRS for instructions on how to determine if a provider is enrolled in the Connecticut Medical Assistance Program.
Enrollment Application Fees	Section 1866(j)(2)(C) of the Affordable Care requires the Connecticut Medical Assistance Program to 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). If the institutional provider has already paid the fee to another state’s Medicaid or Children’s Health Insurance Program (CHIP) or is in the process of enrolling in another state’s Medicaid/CHIP program and will pay an application fee to that state. In that case, the institutional provider is exempt from paying the fee to the Connecticut Medical Assistance Program (CMAP). If it is determined that an application fee is due, the institutional provider 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.

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How to Determine if Provider is Enrolled	The Department of Social Services (DSS) has made a list available of enrolled providers, or providers that are in the process of enrolling, who are eligible to order services on behalf of CMAP clients, or who may make referrals for such clients. This list also includes providers who are eligible to prescribe; however, the following provider types are not licensed to prescribe drug products and may only order or refer services for HUSKY clients: • Chiropractors • Therapists • Opticians • Behavioral Health Clinicians • Naturopaths This list, which is updated weekly, is located on the Home page of the provider's secure Web site at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links. This list should **NOT** be used to refer clients for services as it includes providers who are only enrolled for OPR purposes, and also providers not accepting new patients. In order to locate a provider accepting new patients, clients may follow the procedures outlined in Chapter 10 – Web Portal / AVRS to conduct a provider search through the appropriate Administrative Services Organization (ASO).
Gainwell Technologies	Gainwell Technologies is responsible for processing the enrollment/ re-enrollment applications for all provider types. The provider enrollment/re-enrollment procedures appear later in this chapter. For provider application questions, providers may access the Web portal at www.ctdssmap.com or contact the Provider Assistance Center toll free at 1-800-842-8440 between the hours of 8:00 a.m. – 5:00 p.m. Monday through Friday, excluding holidays, or by writing to: Gainwell Technologies Provider Enrollment Unit P.O. Box 5007 Hartford, CT 06102-5007 Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information. The number is 1-866-604-3470.
Department of Social Services (DSS)	Once Gainwell Technologies has reviewed an application for completeness, the Department of Social Services' (DSS') Quality

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Assurance Unit reviews each application and makes the final decision on the approval/denial of that application.

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3.2 In-State Enrollment

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Overview

In-state enrollment procedures are used by in-state providers, as well as border hospitals. In-state providers are defined as those providers within the state of Connecticut that furnish or are capable of furnishing medical services or goods to Connecticut Medical Assistance Program clients or applicants under the terms of an agreement with the Department of Social Services. Border hospital status is determined by the Department of Social Services.

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Program Information

Provider Type	General Information
All Providers	Providers that successfully enroll in the Connecticut Medical Assistance Program may be eligible to submit claims in the following programs: • HUSKY A • HUSKY B • HUSKY C • HUSKY D For a description of each of these programs, providers should refer to Chapter 1 - Introduction. To access this chapter from the Web portal at www.ctdssmap.com, select Information, then Publications and scroll down to the link for Chapter 1. For specific claim billing instructions, providers should refer to Chapter 8 – Provider Specific Claims Submission Instructions of the Provider Manual. To access Chapter 8 from the Web portal at www.ctdssmap.com, select Information, then Publications. Scroll down to Provider Manual Chapter 8 and select the appropriate provider type from the drop-down box.
Pharmacy Providers	Pharmacy providers that successfully enroll in the Connecticut Medical Assistance Program are eligible to submit claims for clients in the programs listed above. Pharmacy providers are also eligible to submit claims for clients in the following program: • Connecticut AIDS Drug Assistance Program (CADAP) Providers and clients must be enrolled through the Department of Public Health's pharmacy benefit manager, Prime Therapeutics Management LLC. For contact information, please reference Chapter 1 - Introduction.
Dental Providers	Dental providers that successfully enroll in the Connecticut Medical Assistance Program are eligible to submit claims for clients in the following programs: • HUSKY A • HUSKY B • HUSKY C • HUSKY D

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Submission	Enrollment/Re-enrollment Information
Enrollment Process	All providers are required to submit their application via the Web at www.ctdssmap.com by selecting Provider, then Provider Enrollment. Failure to do so will result in the return of the paper application, thus delaying your enrollment. If you are unable to submit your application via the Web portal, you may submit a paper application to Gainwell Technologies only if it is accompanied by a letter that requests an exception to this requirement with details of the reason for this request. Questions on provider enrollment can be directed to the Provider Assistance Center (PAC) toll free at 1-800-842-8440 between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding holidays. Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information. The number is 1-866-604-3470. Note: The start date for enrollment is based on the effective date entered on the provider's application. Gainwell Technologies is allowed to accept retroactive start dates for up to six (6) months from the date the application was signed. Retroactive dates for enrollment are only reviewed if the provider is licensed and meets all of the enrollment requirements for the retroactive period. If a provider needs a retroactive start date greater than six (6) months, the provider must send justification, on a letterhead, explaining why this date is requested. Gainwell Technologies forwards requests that are greater than six (6) months to DSS for special approval. DSS reviews and approves these requests on a case-by-case basis.
Enrollment Wizard (Web)	The Gainwell Technologies Provider Enrollment Wizard is located at www.ctdssmap.com. 1. From the Home page click on the Provider tab, then click on Provider Enrollment. 2. Then click next to begin the enrollment process. 3. Through a series of screens and prompts, the Wizard easily guides you step-by-step through the enrollment process. 4. Upon completion of the Wizard, you will receive an Application Tracking Number (ATN) and will have an opportunity to print a hard copy of the application submitted via the Web. **Please do not send the hard copy to Gainwell Technologies.** 5. Depending on your provider type, there will be some final instructions for enrollment. These instructions may

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include the submission of additional documentation to Gainwell Technologies, based on the taxonomy/provider type/specialty of the provider. If your provider type and specialty require an application fee to be paid, the application cannot be processed until either the fee is received or proof of payment to Medicare or another State's Medicaid program can be validated. (Note: Out-of-state providers will be required to send in a copy of their license.) Your enrollment application cannot be fully processed without receipt of this supporting documentation. The ATN assigned by the Enrollment Wizard must accompany this paper documentation.

NOTE: Once a Web application has been submitted, a provider cannot return to the application to make modifications. Instead, paper corrections need to be submitted to Gainwell Technologies' Provider Enrollment Unit. Additionally, once an application has been started, a provider cannot save the application and return to it later for completion.

Enrollment

The purpose of the Provider Enrollment process on the internet is to allow the provider to submit an enrollment application for the Connecticut Medical Assistance Program on the Public Web site. Access to this application does not require a log in. Any user who has internet access can utilize this application. The Web application collects the entered provider enrollment data and forwards it to the approval process. Some providers may also be required to submit follow on documentation to the application for their provider type, e.g., certification, licensure. Out of State providers can also use this application once the service has been approved for payment consideration by DSS. The application must be completed in its entirety. The application cannot be saved for later completion and cannot be modified once submitted.

Providers must enroll and check the status of an enrollment application on the internet. Providers can access the Provider Web page through the Public Web site to begin the process for both inquiring on a current application and submitting a new application.

Before beginning the enrollment/re-enrollment process online, it may be helpful to gather the following information which may be required:

- Providers joining an organization(s) must enter a valid, CMAP enrolled, NPI or Medicaid ID of the organization(s). The organization must be **ACTIVELY** enrolled in CMAP in order to continue with the performing provider's application. If the organization(s) is **NOT** actively enrolled, the performing provider's application **WILL NOT** be able to be submitted.
- Full 9 digit zip codes for all addresses
- License Number
- Out of state providers must submit a copy of their license to Gainwell Technologies. This documentation must contain the Application Tracking Number (ATN) assigned at the end of this enrollment.

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- 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 providers wishing to enroll must first submit a claim to Gainwell Technologies

The online provider enrollment process begins when the provider opens the provider enrollment Web page from the hot link. The provider will be prompted through a series of steps to complete data required to submit the application for review and approval including the submission of appropriate follow on documentation for their provider type via mail, e.g., certification, licensure.

Once all the data is entered on each screen, providers will click the 'Next' button. If errors are detected, the provider will be prompted with an error message to correct the entry before being allowed to continue. Completed applications are then submitted to the interChange system which will display the enrollment data summary, signature page, a successful completion message with the assigned Application Tracking Number (ATN), and request for follow on documentation needed to complete the enrollment. The confirmation panel will also give the provider the opportunity to print or save a copy of the completed application.

The online enrollment status tracking process begins when the provider opens the provider enrollment tracking Web page from the hot link. The provider will be prompted to fill out the ATN and their last name or business name for the interChange system to retrieve the application status. A message is displayed back to the provider displaying a summary result of ATN, Name, Date Received, and Status.

Add Alternate Service Location Address

The Internet add alternate service location address process begins when the provider is expanding their number of practice locations. The Affordable Care Act (ACA) requires that providers submit a new application requesting approval in these situations, and that that application be subject to all screening requirements (such as licensure verification, if applicable). (If the provider is moving office locations and not expanding the overall number of practice locations, an application is not required. This change can only be done via the Secure Web portal Demographic Maintenance panels.) In these instances, providers can begin this application by logging in to their Secure Web portal account from the www.ctdssmap.com Web site. Once logged in, select Provider > Add Alternate Svc Loc Address and the provider's existing data is then pre-populated on the re-enrollment panels that are presented to the provider. Once the provider validates or modifies the data and adds the new alternate service location address(es), the provider clicks the 'Submit' button and the application proceeds through the same process as the re-enrollment process. The provider may also be required to submit via mail the appropriate follow on documentation with the ATN for their provider type, e.g., certification, licensure.

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Please note that a provider can designate a clerk(s) to submit add alternate service location address applications.

There are some provider types/specialties that are licensed by site, such as Urgent Care Clinics, and so are not permitted to submit an add alternate service location address. These providers must enroll each site separately to obtain an AVRS ID specific to that site.

All Applications

The provider can access the enrollment, enrollment tracking, and re-enrollment self-service features from the Web Portal at www.ctdssmap.com

Navigation Path: [Public Web site] – [Provider – Provider Enrollment] or [Public Web site] – [Provider – Provider Enrollment Tracking] or [Public Web site] – [Provider – Provider Re-enrollment]

Or:

[Portal Public Home Page] – [Provider] – [Login to Secure site] – (log in) – [Provider] - [Add Alternate Svc Loc Address]

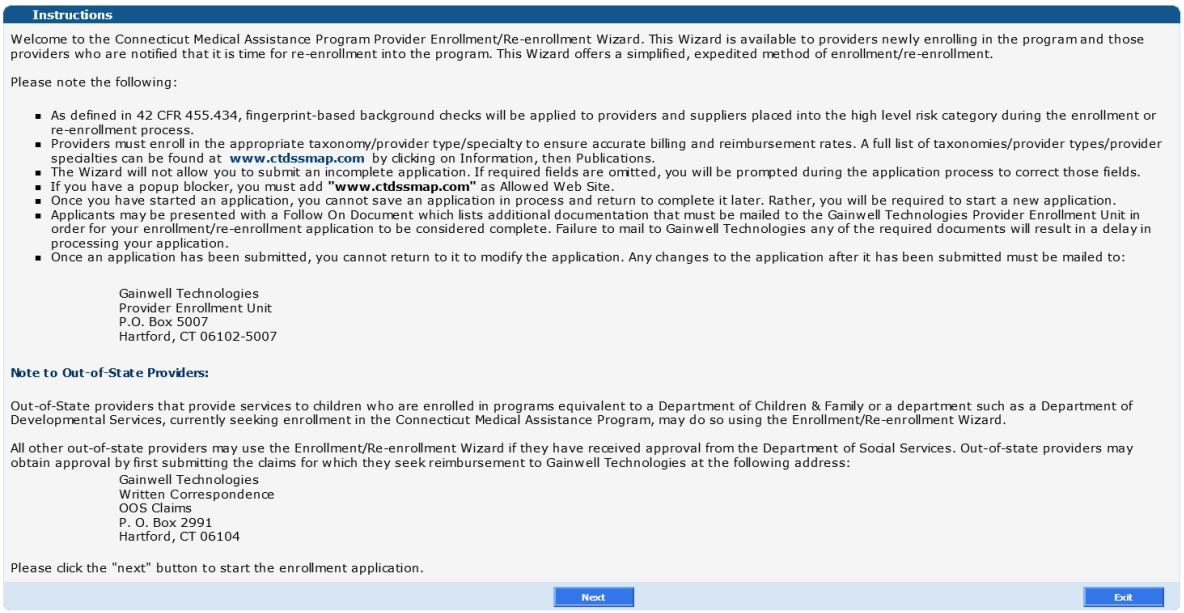
Step-by-Step Online Enrollment Instructions

The following pages provide detailed instructions for enrolling on the Web portal. Providers are required to submit their application via the Web at www.ctdssmap.com by selecting Provider, then Provider Enrollment. Failure to do so will result in the denial of the paper application, thus delaying your enrollment. If you are unable to submit your application via the Web portal, you may submit a paper application to Gainwell Technologies with a letter that requests an exception to this requirement with details of the reason for this request.

The following sections provide detailed instructions for the Web enrollment tool. Please note that enrollment requirements for residents vary from other provider types. A complete guide to resident enrollment can be found in the following:

Resident Step by Step Enrollment Guide

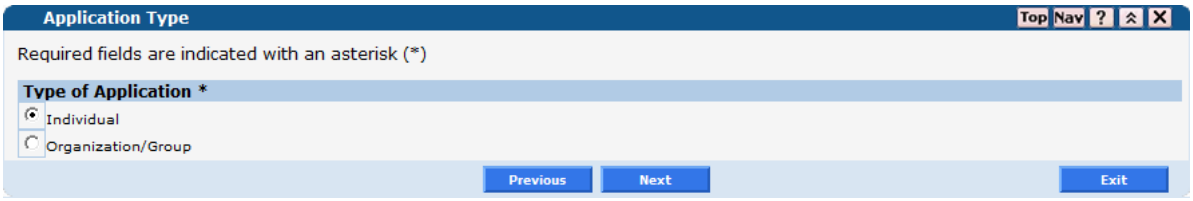
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Provider Enrollment/Re-enrollment Wizard Instructions Panel

To Enroll a Provider:

Step	Action/Response
1.	Open the Public Web site.
2.	From the **Provider** menu, select **Provider Enrollment**.
3.	Review the instructions on the panel.

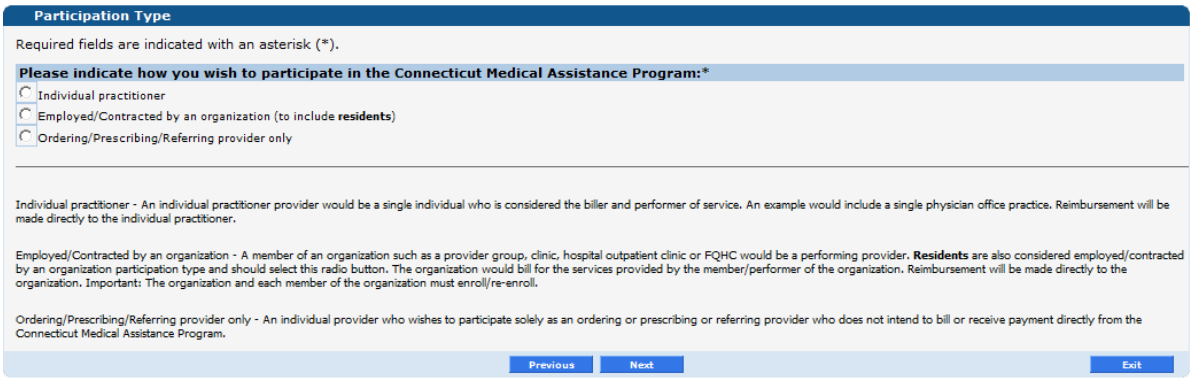


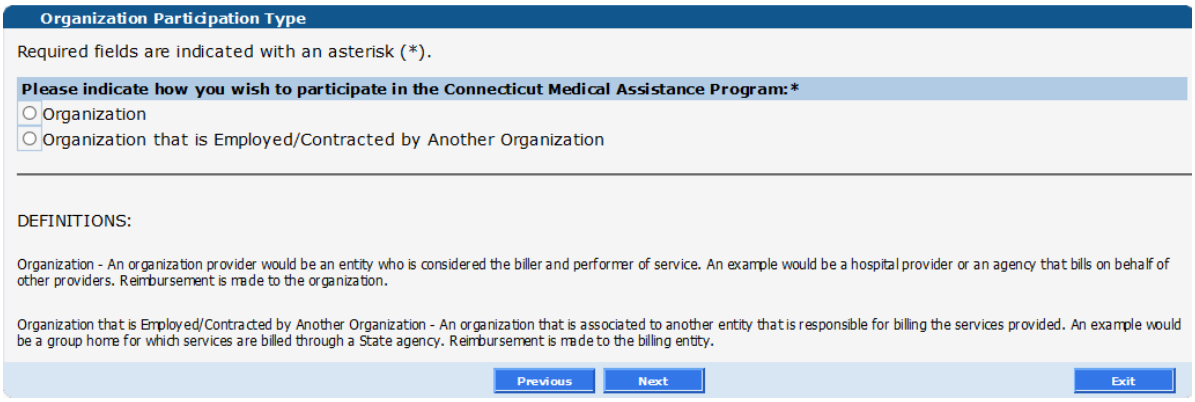
Application Type Panel

Step	Action/Response
4.	In the panel above, use radio buttons to select **Application Type**.

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	Click next **next** to continue.
5.	The **Participation Type** panel displays. Please note that the Participation Type panel that is displayed will vary slightly based on whether Individual or Organization/Group is selected on the Application Type panel.

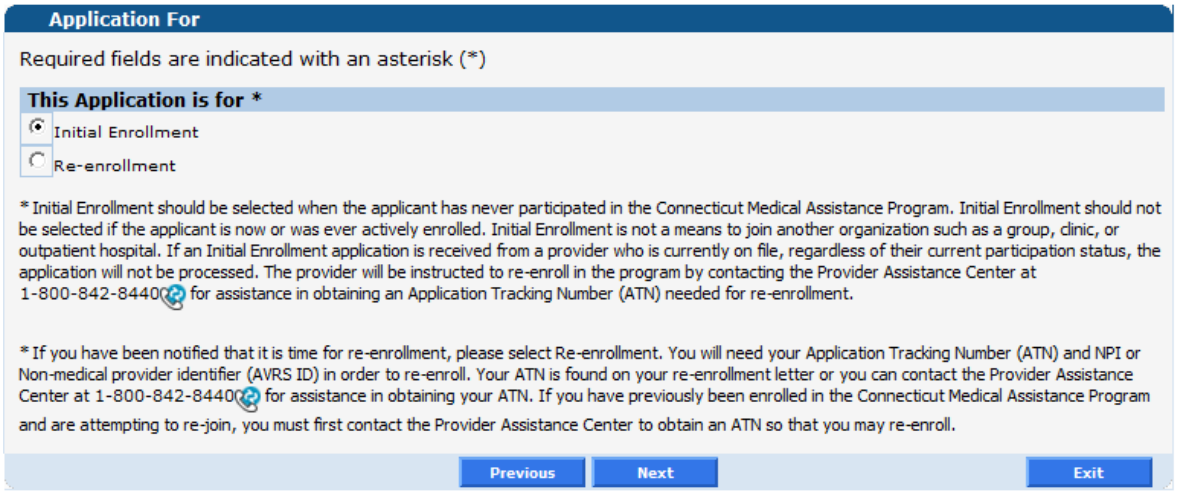




Participation Type Panels

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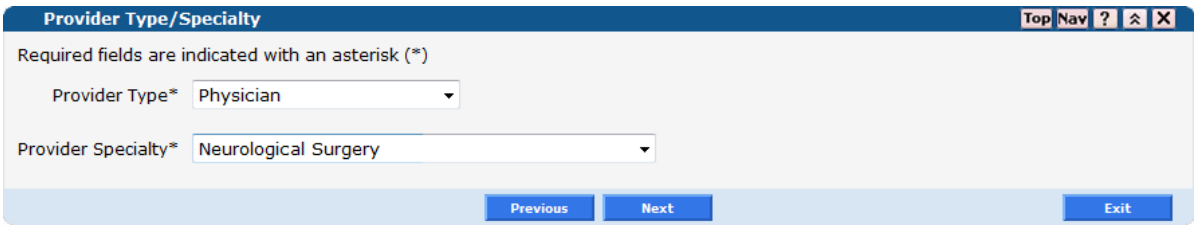
Step	Action/Response
6.	In the individual Participation Type panel above, use radio buttons to select **Individual practitioner, Employed/Contracted by an Organization (to include residents), or Ordering/Prescribing/Referring Provider Only**. In the Organization Participation Type panel above, use radio buttons to select **Organization or Organization that is Employed/Contracted by Another Organization**.
7.	Click next **next** to continue. The **Application For** panel displays.



Application For Panel

Step	Action/Response
8.	Identifies the application as being for initial enrollment or re-enrollment. This field defaults to *Initial Enrollment*. It may be updated to re-enrollment; in which case the provider is presented with the re-enrollment application.
9.	Click next **next** to continue. The **Provider Type/Specialty** panel displays.

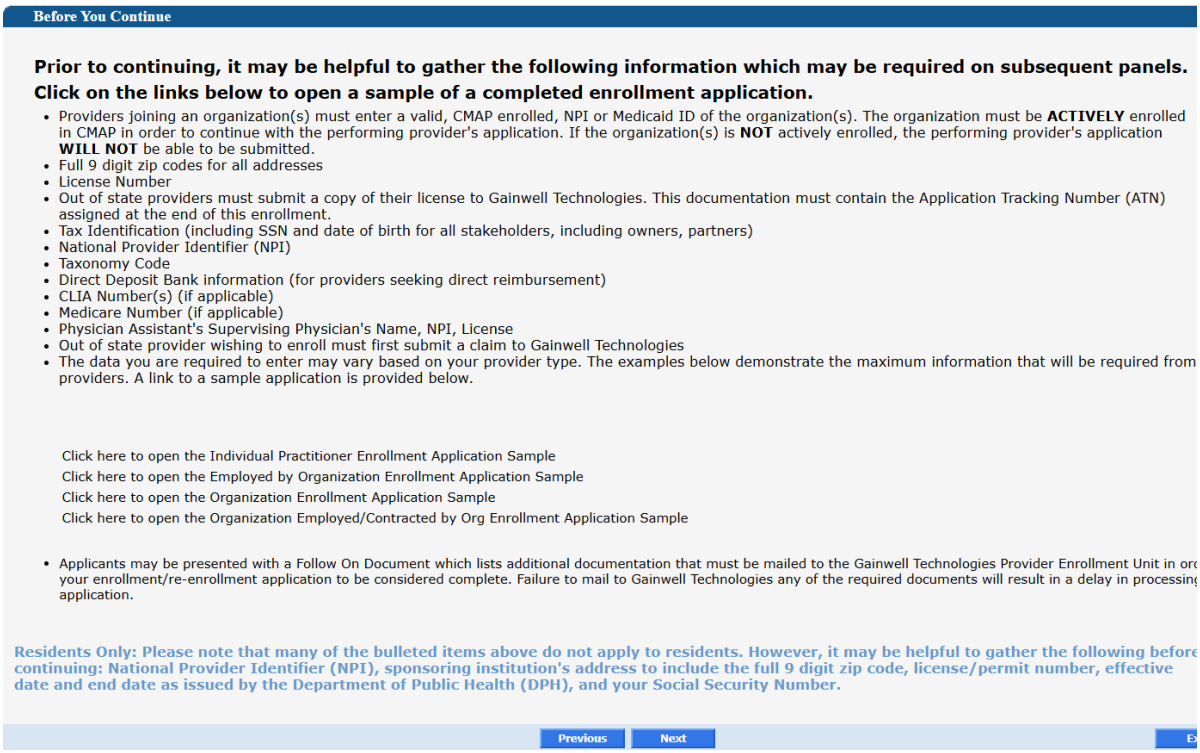
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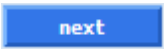
Provider Type/Specialty Panel

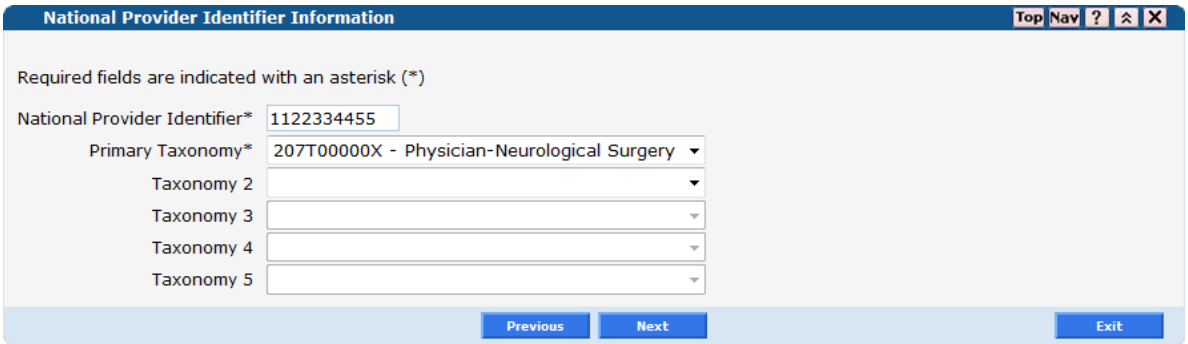
Step	Action/Response
10.	Select your **Provider Type** from the drop-down list.
11.	If applicable, an additional drop-down menu will appear; select your Provider Specialty. Not all provider types require/allow for the selection of a provider specialty. If you are an ambulance transportation provider, before you leave this panel, the following additional question must be answered: “Are you enrolling to provide paramedic intercept services only?”. Click next **next** to continue. The **Before You Continue** (a) panel displays the following for Individual, Organization, (individual) Employed/Contracted by an Organization, or Organization that is Employed/Contracted by Another Organization provider. The **Before You Continue** (b) panel displays the following for Ordering/Referring/Prescribing providers.

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Before You Continue Panel

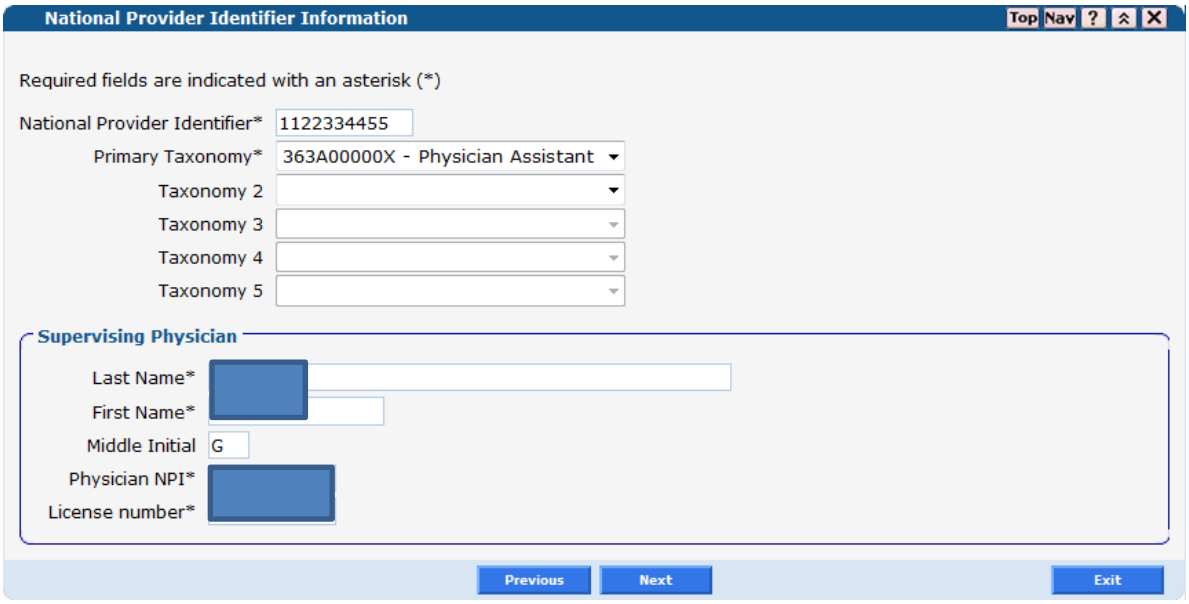
Step	Action/Response
12	Read the information displayed on the panel.
13	Click  **next** to continue. The **National Provider Identifier Information** panel displays.



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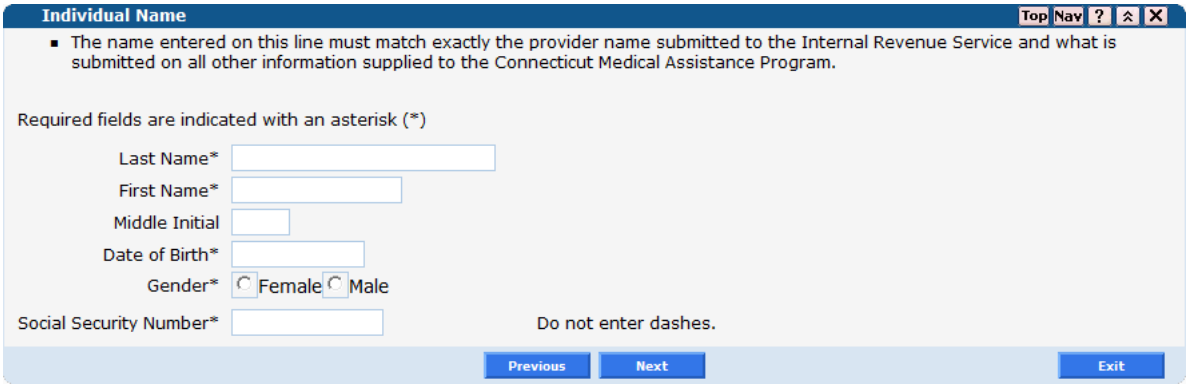
National Provider Identifier Information Panel

Step	Action/Response
14	Depending on your provider type, an **NPI and Primary Taxonomy** may be required. Additional taxonomies may be selected if applicable.
15	Click next **next** to continue. For enrolling Physician Assistants, the **Supervising Physician** panel displays (see below).



National Provider Identifier Information Panel When Enrolling a Physician Assistant

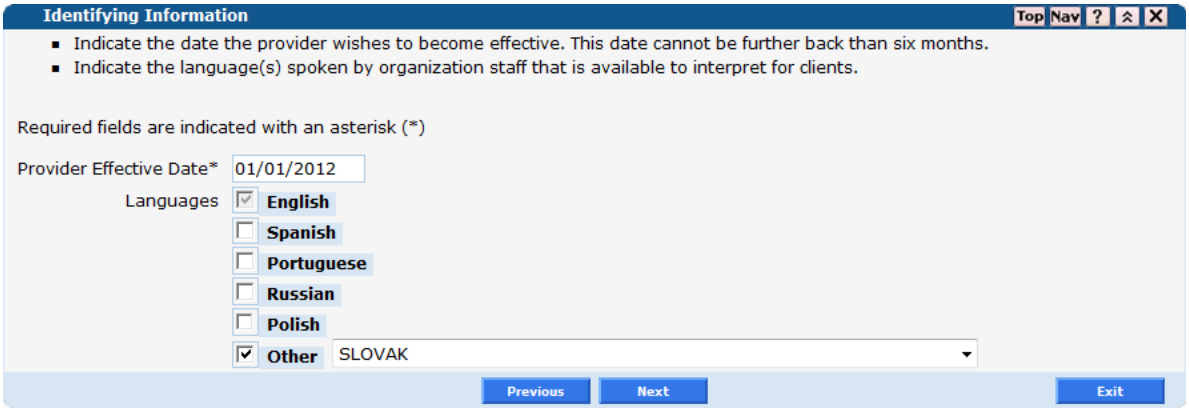
- This example shows the requirement for *Supervising Physician* information when enrolling a Physician Assistant.



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Individual Name Panel

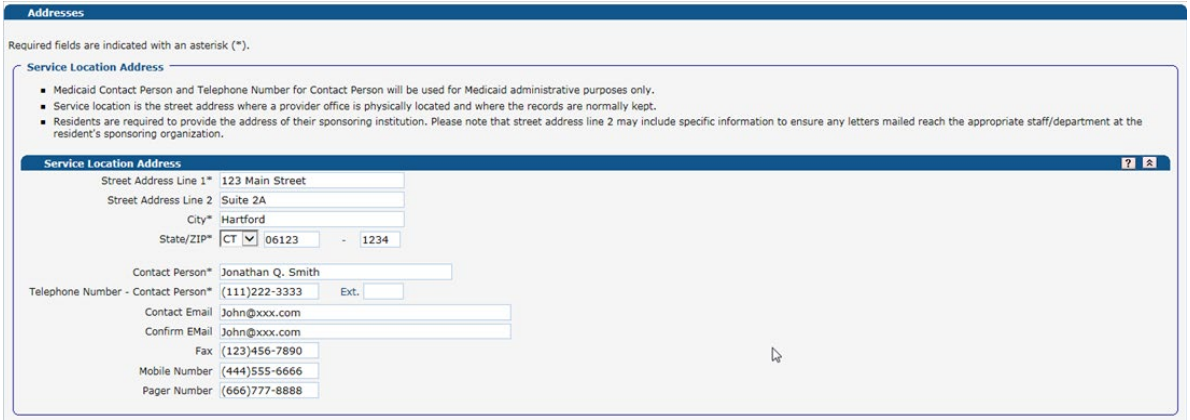
Step	Action/Response
16.	Fill in the available fields with the appropriate information on the **Individual Name** panel. This panel is only displayed for Individual, Employed/Contracted by an Organization, and Ordering, Referring, Prescribing providers. The information submitted must be consistent across all documentation supplied to the Connecticut Medical Assistance Program (CMAP).
17.	Click next **next** to continue. The **Identifying Information** panel displays for Individual, Organization, (individual) Employed/Contracted by an Organization, and Organization that is Employed/Contracted by Another Organization providers.



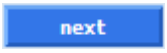
Identifying Information Panel

Step	Action/Response
18.	For Organization and Organization that is Employed/Contracted by Another Organization providers, this panel also includes an Organization Name field. Indicate the name of the organization in this field.
19.	Indicate the date the provider wishes to become effective. This date cannot be further back than six months. Also indicate the language(s) spoken by the organization staff that is available to interpret for clients.
20.	Click next **next** to continue. The **Service Location Address** panel displays.

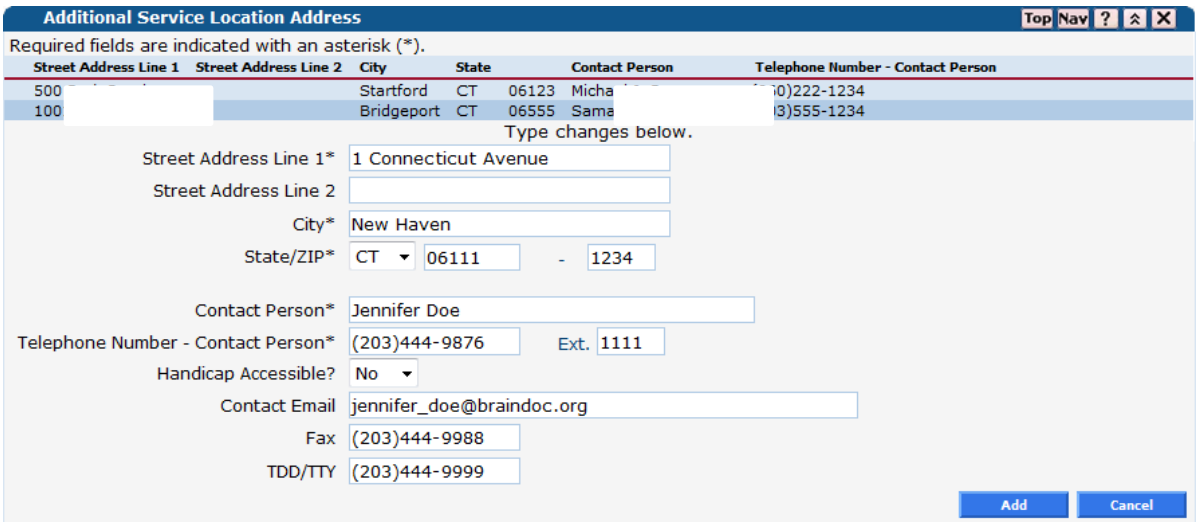
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Service Location Address Panel

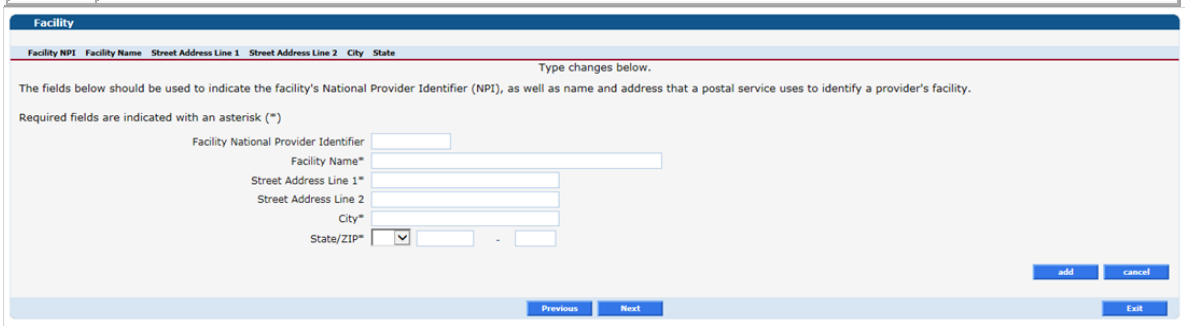
Step	Action/Response
21.	Enter information for the required address types: **Service Location; Mailing Address; Home Office Address, Enrollment Address. (Check and Remittance Advice Address and 1099 Mailing Address** are also required for organization and individual practitioners). Please be aware that P.O. Boxes are not allowed in a **service location address.** After entering information into the *Service Location Address* panel, you may copy that information to other panels by clicking **Copy Svc Loc Addr.** **Please note that not all types of providers are required to enter each of the address types above, and not all the fields on the panel above will be displayed for each provider type. If a provider is not required to enter one of the address types or fields above, the panel/field will not be displayed.**
22.	Click  **next** to continue. The **Additional Service Location Address** panel displays.

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Additional Service Location Address Panel

Step	Action/Response
23.	Enter any additional alternate service locations. NOTE: There are some provider types/specialties that are licensed by site, such as Urgent Care Clinics, and so are not permitted to submit an add alternate service location address. These providers must enroll each site separately to obtain an AVRS ID specific to that site.
24.	Click next **next** to continue. For individual, employed/contracted by an organization, and Ordering/Referring/Prescribing, the following **Facility Panel** will be displayed next.

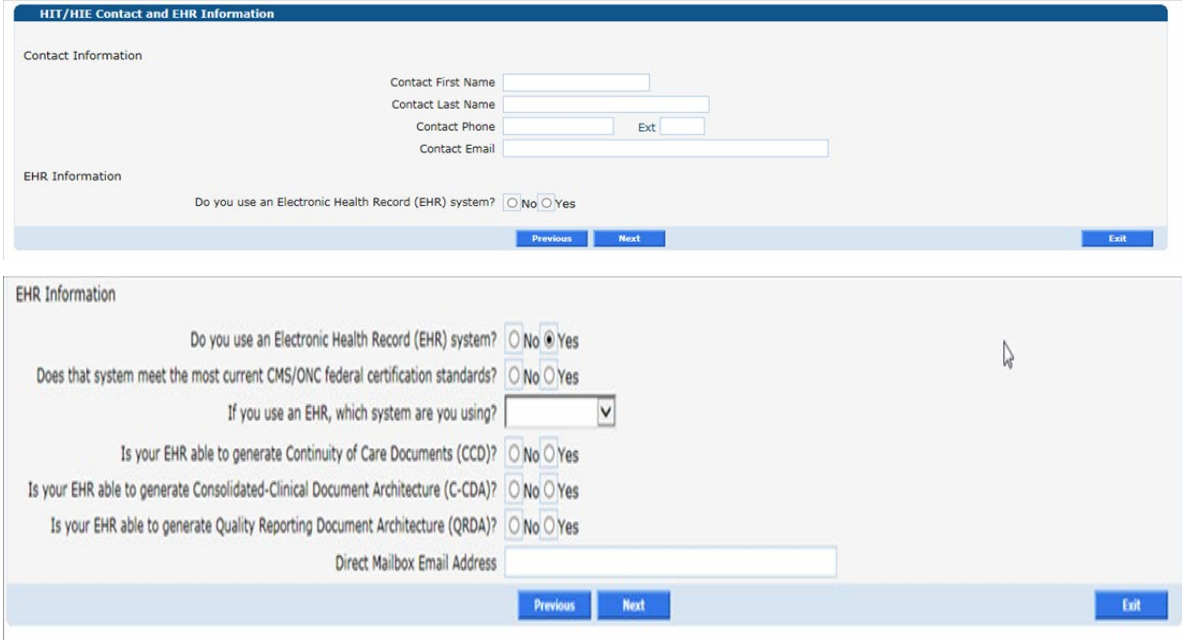


Facility Panel

Step	Action/Response
25.	Enter any facility information.

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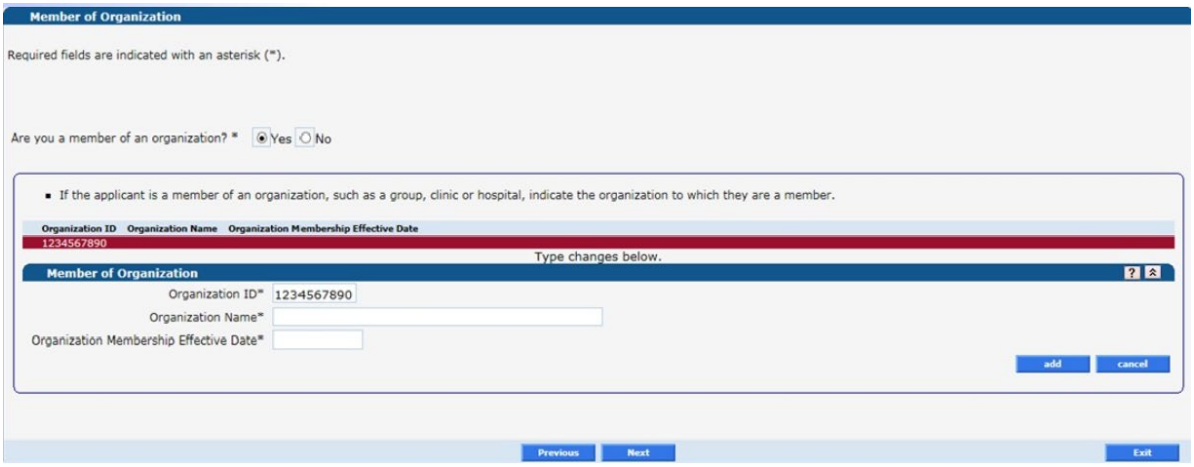
26.	Click next **next** to continue. For individual, employed/contracted by an organization, Ordering/Referring/Prescribing, and organization providers, the following **HIT/HIE Contact and Promoting Interoperability (PI), (formerly EHR Incentive, Program) Information** will be displayed next. When Yes is selected to the Electronic Health Record (EHR) System question, an additional set of questions are displayed on the panel.



HIT/HIE Contact and PI Information Panel

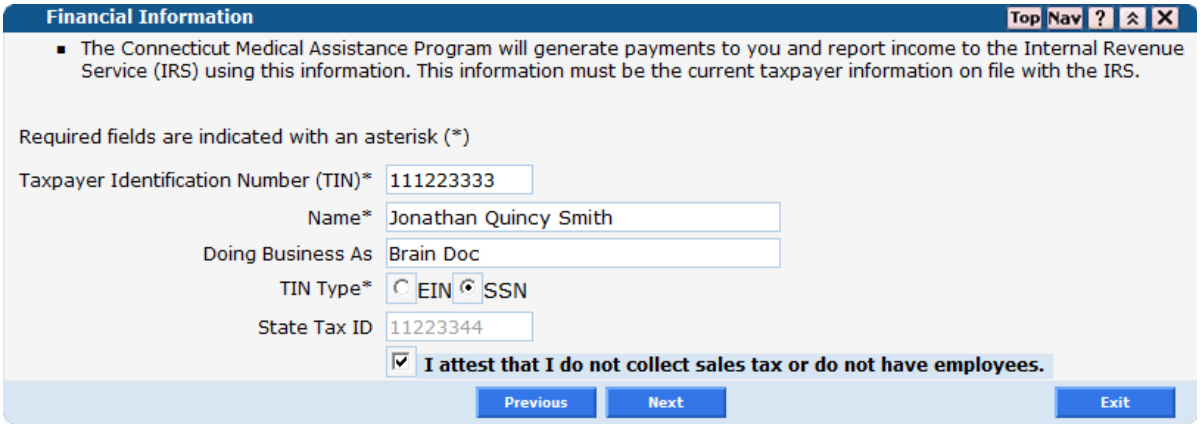
Step	Action/Response
27.	Enter any Health Information Technology (HIT)/Health Information Exchange (HIE) Contact and Promoting Interoperability (PI), formerly EHR Incentive, Program information.
28.	Click next **next** to continue. For individual, as well as all employed/contracted by an organization providers, the following **Members of Organization Panel** will be displayed next. For organization providers, the **Financial Information** panel displays.

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Member of Organization Panel

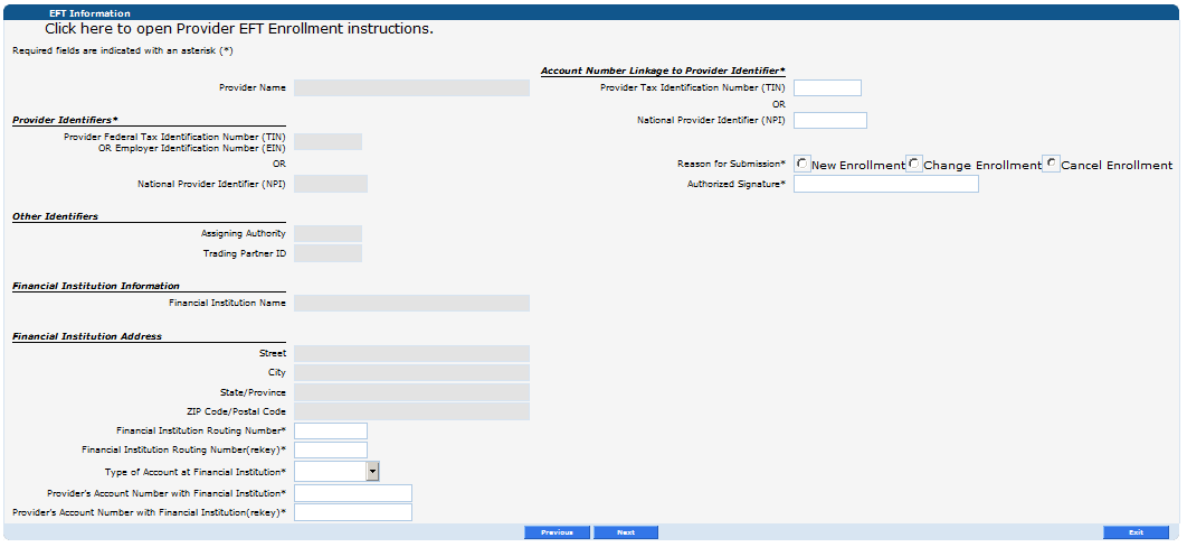
Step	Action/Response
29.	Enter any organizations to which the provider is employed/contracted. Please note that, depending on the type of enrolling/re-enrolling provider, links to additional information may be presented on this panel. Additionally, some provider types are not permitted to update this information upon re-enrollment.
30.	Click next **next** to continue.



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Financial Information Panel (required for Organization and Individual Practitioner Applicants only) and Tax ID Information Panel (required for Organization that is Employed/Contracted by Another Organization)

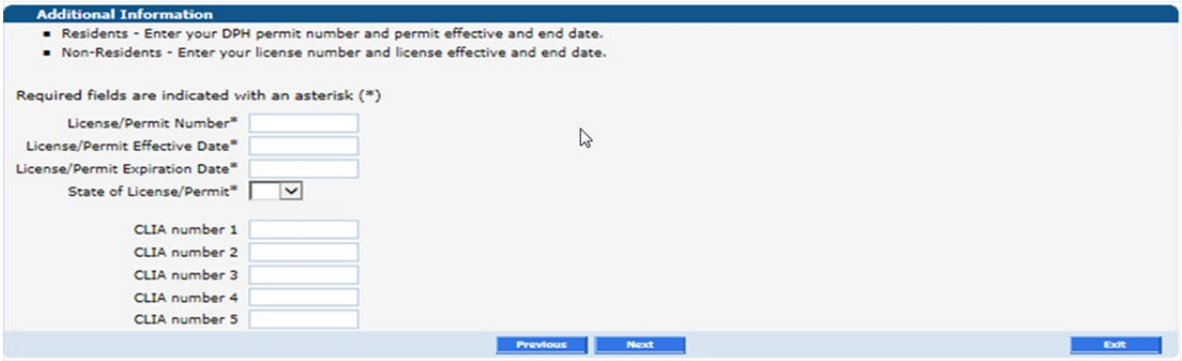
Step	Action/Response
31.	Organization and Individual practitioners are required to submit financial information such as their **Taxpayer Identification Number (TIN)** and **State Tax ID**. If State Tax ID is not provided, you must **attest that no sales tax is collected or have no employees**. This panel will be skipped for providers that indicated they are an individual employed/contracted by an organization or ordering/prescribing/referring only. An organization that is employed/contracted by another organization will be presented with a panel where the provider must supply their TIN and TIN Effective Date.
32.	Click next **next** to continue. The **EFT Information** panel displays.



EFT Information Panel (required for Organization and Individual Practitioner Applicants only)

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Step	Action/Response
33.	Organization and Individual practitioners must enter information regarding the bank account into which they would like to receive reimbursement for the services they provide. This panel will be skipped for providers that indicated they are employed contracted by an organization or ordering/prescribing/referring only. Please note that the information gathered as part of the EFT enrollment process is in accordance with the requirements set forth in the Affordable Care Act 1104 Phase III Operating Rules, specifically the CORE 380 EFT Enrollment Data Rule. Additional information on those requirements can be found on the CAQH Web site at https://www.caqh.org/hubfs/43908627/drupal/core/phase-iii/policy-rules/EFT_Enrollment_Data_Rule.pdf. For specific written guidance and instructions on EFT enrollment, as well as the process to check EFT status and initiate updates once enrolled, please select the following link: EFT Enrollment Instructions
34.	Click next **next** to continue. The **Additional Information** panel may be displayed based on your participation type.

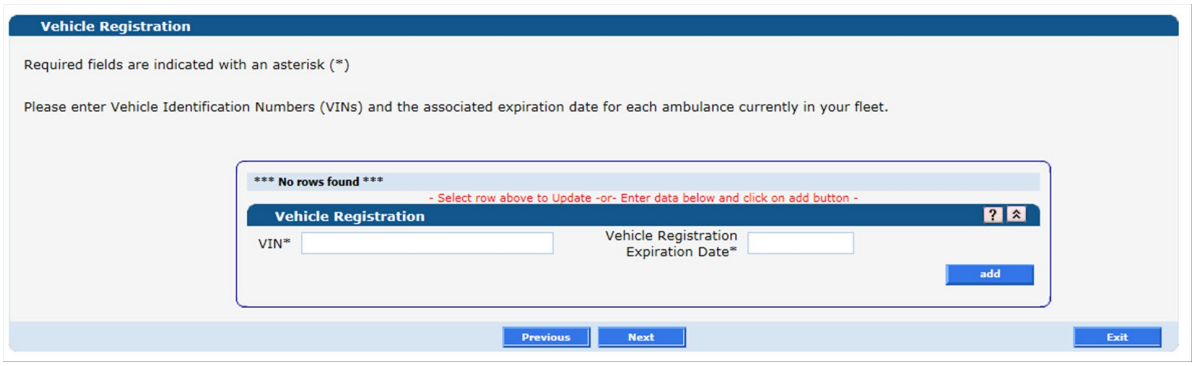


Additional Information Panel

Step	Action/Response
35.	If applicable to your provider type, providers will be required to enter their License number, License Effective Date, License End Date and State of license in the boxes provided. For providers that are licensed through DPH or DCF, the license number must match exactly to the license number on DPH or DCF. A warning error message will be displayed if the license number cannot be found. You may correct the license number or ignore the warning message. CLIA numbers may also be entered but are only required for independent laboratory providers that are enrolling.

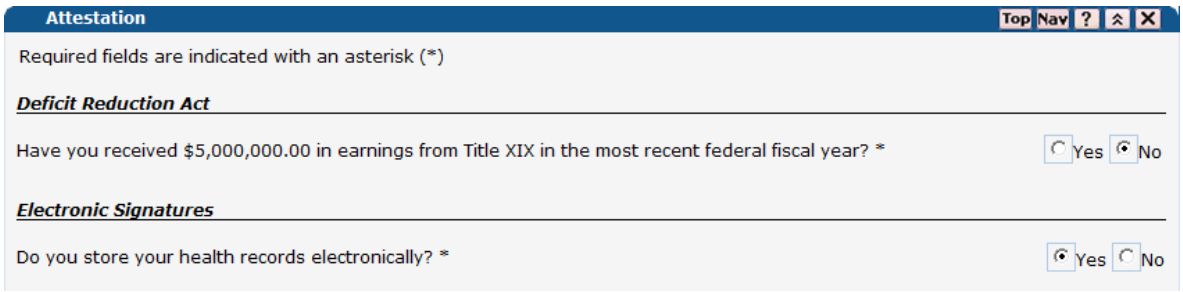
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	Ordering, referring, prescribing providers are not presented with fields to supply CLIA numbers.
36.	Click next **next** to continue. If you are an in-state ambulance transportation provider, the **Vehicle Registration** panel displays.



Vehicle Registration Panel

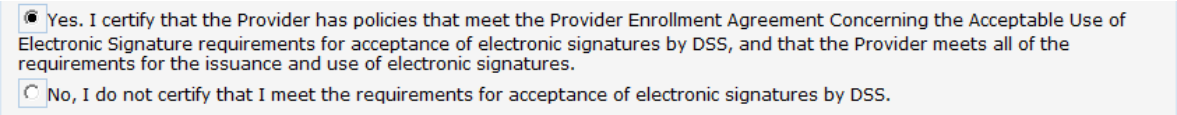
Step	Action/Response
37.	If you are an in-state ambulance transportation provider, you are required to supply Vehicle Identification Numbers (VINs) and their registration expiration dates.
38.	Click next **next** to continue. The **Attestation** panel displays.



Attestation Panel Questions

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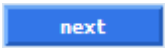
Step	Action/Response
39.	Respond to the questions regarding the Deficit Reduction Act **(only for organization and individual practitioners and not for individuals/organizations employed/contracted by an organization or ordering/prescribing/referring only applications) and Electronic Signatures**.
40.	Answering ***Yes*** to these questions will open the *Deficit Reduction Act Affidavit* and *Electronic Signature Attestation respectively;* read the attestation(s) and signify whether or not you comply with the stated requirements. The system will not let you proceed with the application until you complete the attestation.



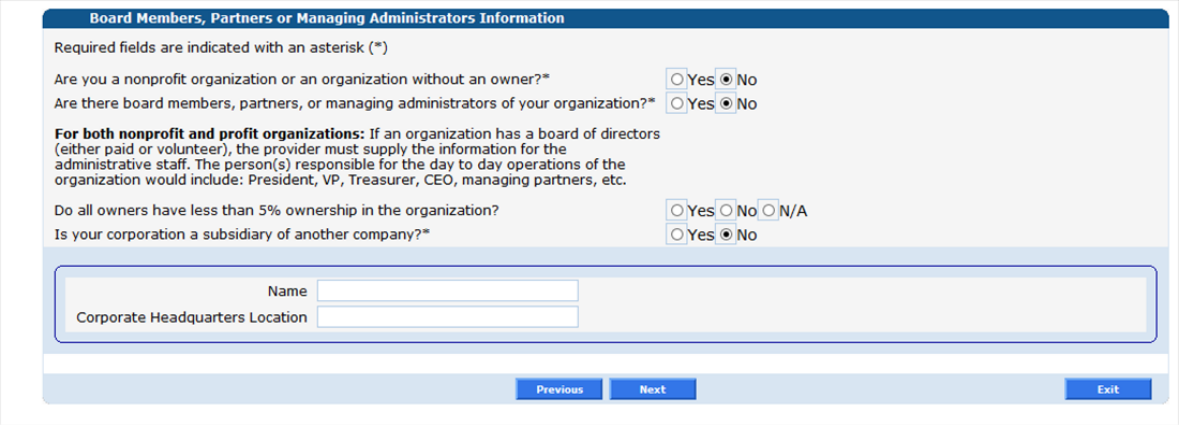
Attestation Panel Certification of Compliance



Medicare Information Panel

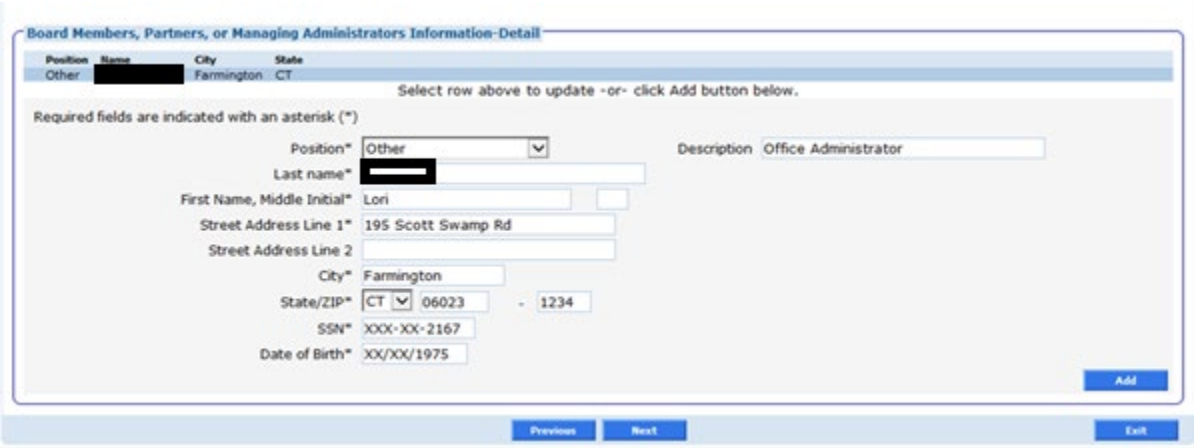
Step	Action/Response
41.	If applicable to your provider type, providers will be required to indicate if they are enrolled in Medicare and if so, enter their **Medicare Number(s)** and **Effective Date(s)** in the boxes provided. Hospital providers will be required to submit their CCN.
42.	If applicable, the panel also allows providers to specify that they are enrolling solely for the purpose of payment consideration of Medicare crossover only claims. **Please note:** If this option is selected, any other claim types submitted will be denied. Providers that select this option will not appear in the Connecticut Medical Assistance Program provider directory.
43.	Click  **next** to continue. The **Board Members, Partners, or Managing Administrators Information** panel displays. This panel will only be displayed for Organization, Individual, and Organization that is Employed/Contracted by Another Organization practitioners.

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Board Members, Partners, or Managing Administrators Information Panel

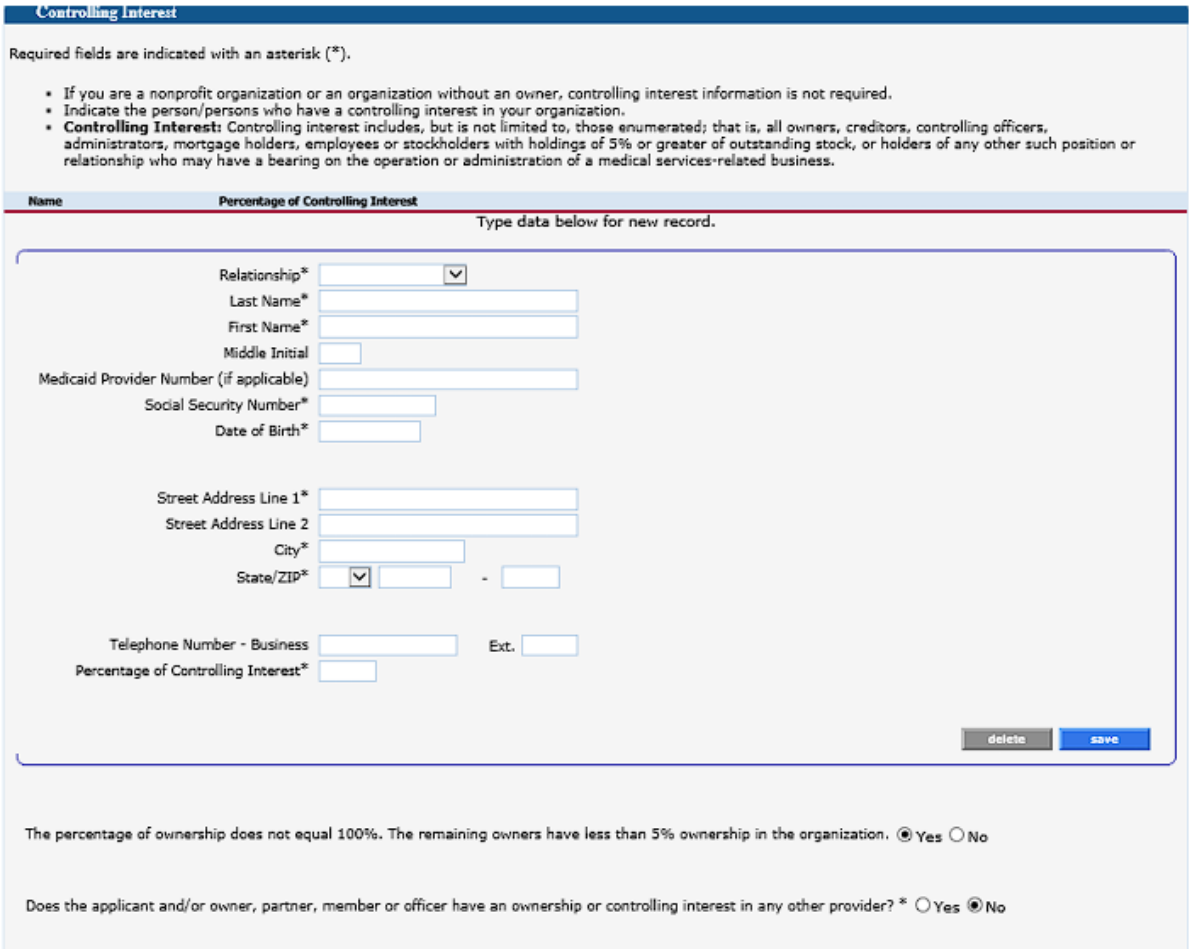
Step	Action/Response
44.	Enter responses to each of the questions. If yes to the last question, supply the **Name** and **Corporate Headquarters Location**.
45.	*If you answered **Yes** to the board members, partners or managing administrators of your organization, you will be required to enter details about that board member(s), partner(s), or managing administrator(s). The panel displayed below appears* If you answered no, click next **next** to continue. The **Controlling Interest** panel displays.



Board Members, Partners, or Managing Administrators Information – Details Panel

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Step	Action/Response
46.	Providers will be required to supply the position, name, address, social security number, and date of birth for each board member/partner/managing administrator.
47.	Click next **next** to continue. The **Controlling Interest** panel displays.

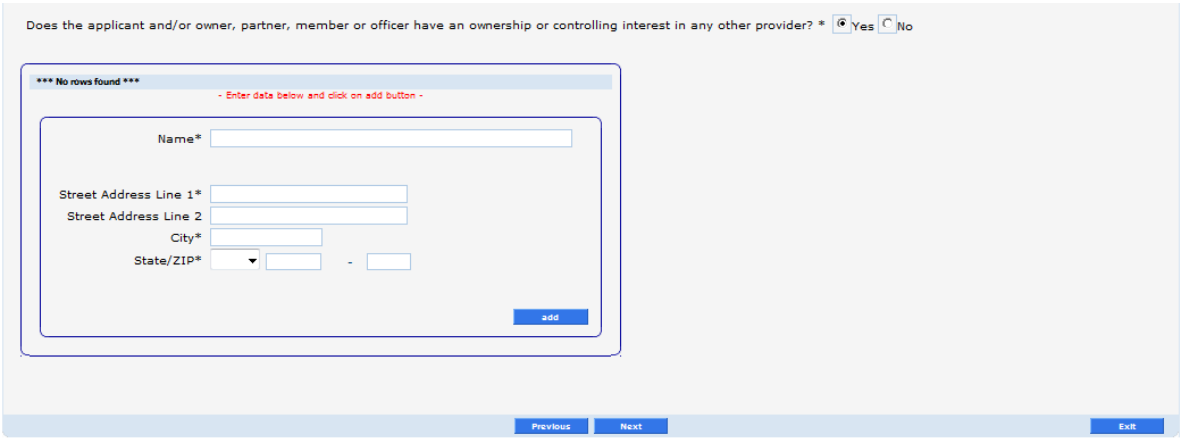


Controlling Interest Panel

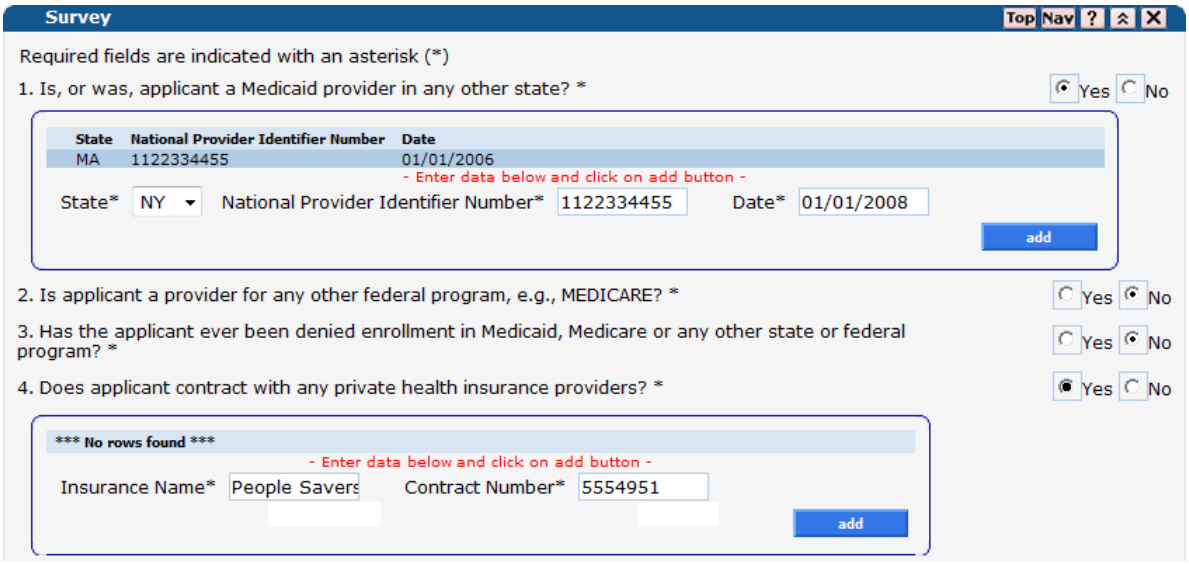
Step	Action/Response
48.	Organization, Individual, and Organization that is Employed/Contracted by Another Organization practitioners must disclose whether or not they have a controlling interest in any vendors of special service categories such as drugs/pharmacy, medical

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	supplies/durable medical equipment, transportation, etc. Providers are required to enter name, relationship, social security number date of birth, address, and percentage of controlling interest.
49.	Click add to add another controlling interest or proceed to answer the questions on the panel. *If you answered **Yes** to having a controlling interest in another health care provider, you will be required to enter information regarding that business. The panel displayed below appears.* If not, the **Survey** panel displays.



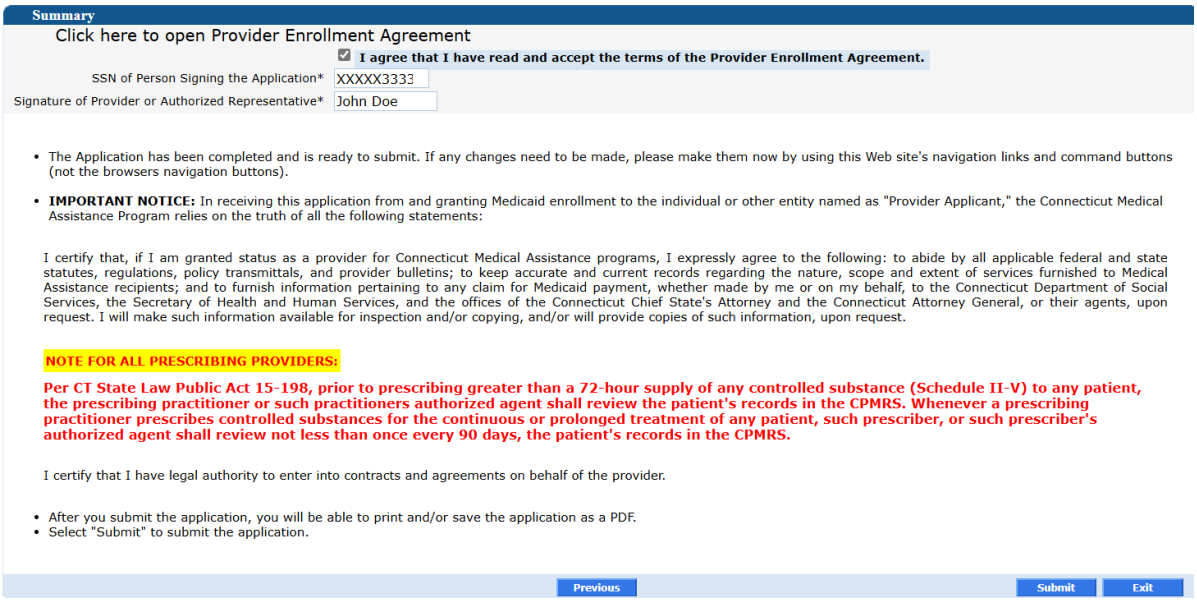
Controlling Interest in Other Health Care Providers Panel Details



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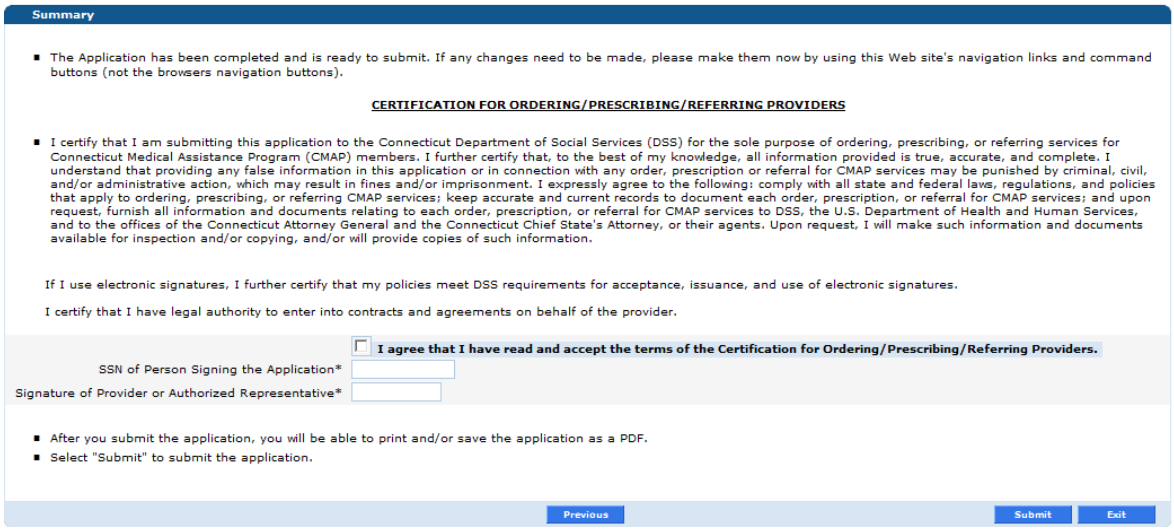
Survey Panel

Step	Action/Response
50	*Answer the questions either **Yes** or **No** – answering yes to any of these questions will open fields requiring you to submit additional information. Please note that the panel above only provides a sample of the survey questions that may be presented to providers.*
51	Click add **add** after entering the required supplemental data. The **Summary** panel (a) displays for Individual, Organization, and Employed/Contracted by an Organization providers. Providers must click on the link to review the provider agreement. Please note that a limited number of providers will be prompted to submit a copy of their contract with DSS in place of the provider agreement. The **Summary** panel *(b)* displays for Ordering, Referring, Prescribing providers. Providers must click on the link to review the certification statement.

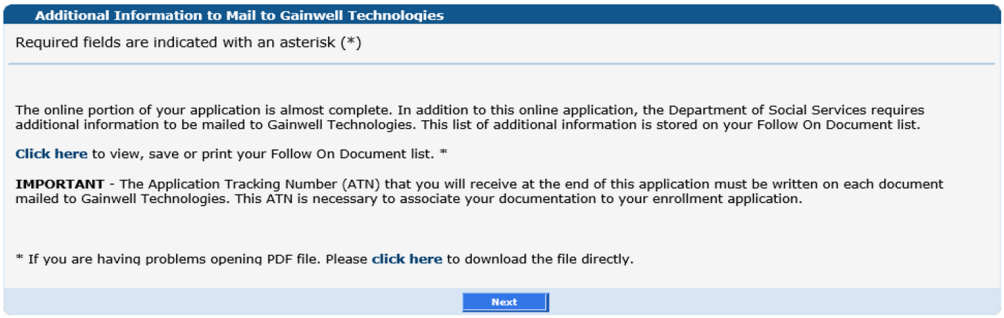


Summary Panel for Organization, Individual, and Employed/Contracted by an Organization Providers Panel *(a)*

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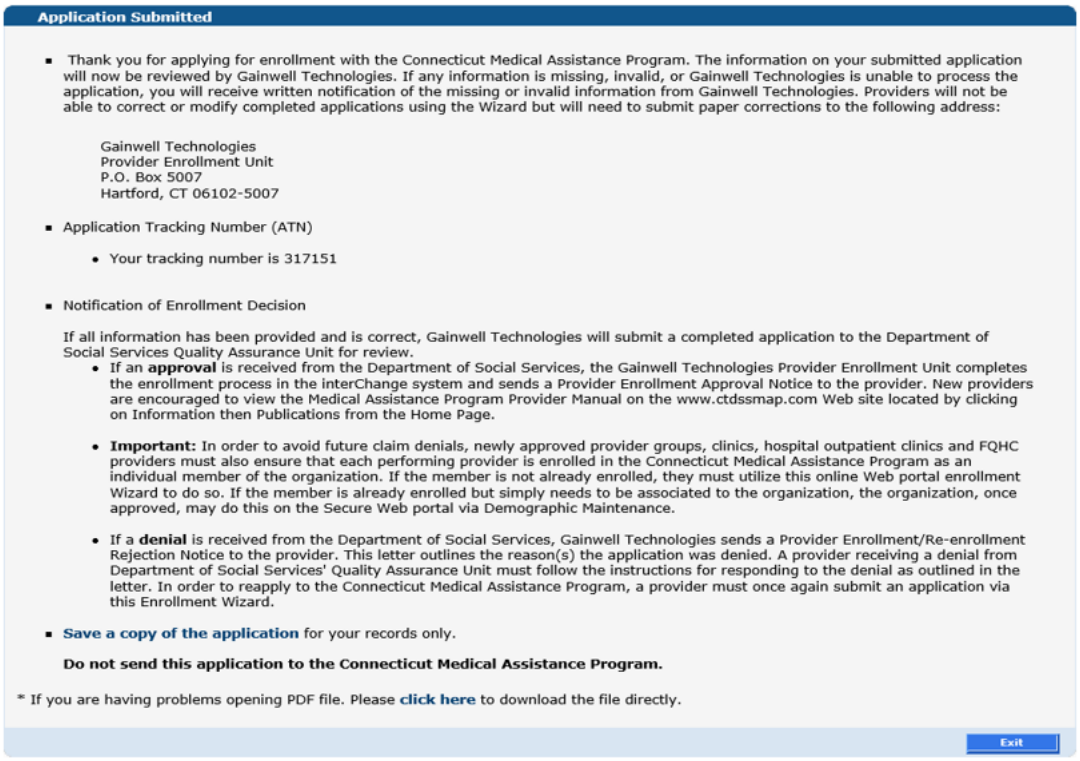
Summary Panel for Ordering, Prescribing, Referring Providers Panel *(b)*



Additional Information to Mail to Gainwell Technologies

This panel will display if additional information is required to be mailed to Gainwell Technologies based on your provider type. Click on the given link to view, save, or print the list of required Follow On Documents.

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Application Submitted Panel

Using Provider Matrix Page to Complete Enrollment/Re-enrollment/Add Alternate Service Location Application

Providers can access this page from the Provider menu on the Public Web site to obtain information on the next steps after the online enrollment/re-enrollment/add alternate service location application has been submitted. Information on this page details the additional forms and appropriate follow on documents by provider type that must be submitted upon completion of the enrollment, re-enrollment, or add alternate service location address application. Note: For those providers that must enroll/re-enroll/add alternate service location address on the Web portal, these additional forms have either been included as part of the online Web portal Wizard or will be presented as a follow on document at the completion of the application. To access a sample of the Provider Matrix page available on the Public Web site, click on the following link:

Provider Matrix Page

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Enrollment Packet (Paper)	If submitting a paper application with a request for exception, providers may download the paper application from the Web portal at www.ctdssmap.com. To access the application, select Information, then Publications, and scroll down to the link for Provider Enrollment Application in the Forms section. If enrolling as ordering/prescribing/referring provider only, select the link for the Ordering, Prescribing, Referring Application. Please carefully review the instructions on the first three pages of the application. The requirements for the completion of the application are dependent on whether the enrolling provider is an organization, individual, or employed/contracted by an organization provider. Please note that the application for an ordering/prescribing/referring provider includes only a subset of the sections in the full provider application and presents the provider with a certification statement versus the standard provider agreement.

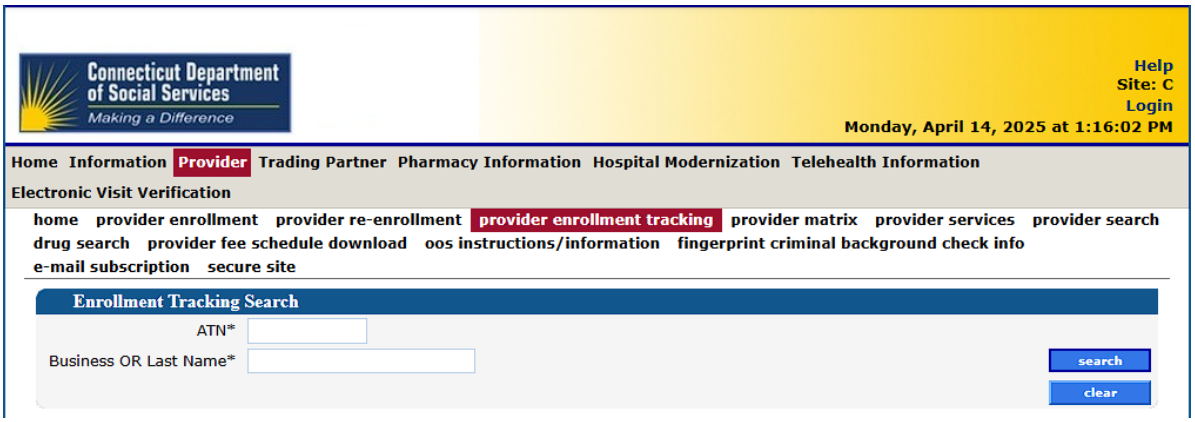
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Where to Send Web Enrollment Follow on Documents	For providers enrolling on the Web, please do not send a hard copy of the application. Providers must only send any additionally required documentation, with the ATN written on top of that documentation. Providers must send in the Web follow on documentation to Gainwell Technologies' Provider Enrollment Unit to the following address: Gainwell Technologies Provider Enrollment Unit P.O. Box 5007 Hartford, CT 06102-5007 If a provider does not return a completed application or all the follow on documents (FODs) in a timely manner, reminder letters are sent. For enrollment applications and FODs, a reminder letter is sent 30 days after the initial information was received. If no response is received from that mailing, the enrollment ATN is closed for lack of response. A Provider Enrollment/Re-enrollment Rejection Notice will be sent to notify the provider that enrollment in the CMAP program has not been processed and the provider is not enrolled in the CMAP program. Providers will not be able to submit claims for payment for any services provided to clients. If at this time the provider chooses to participate in CMAP, a new enrollment application is required. *Please note that each application, once submitted by the provider, must be processed by Gainwell Technologies and the Department of Social Services' (DSS) Quality Assurance Unit. The application must be submitted to allow adequate time for these processes to occur, which typically takes several weeks to complete.

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Application Status Tracking

After submitting an enrollment application providers should monitor the status of their enrollment via the Enrollment Tracking Search. If the application is in a status that the provider does not understand please contact the Provider Assistance Center at 1-800-842-8440. The Provider Enrollment Tracking menu option permits tracking of a recent provider enrollment/re-enrollment/add alternate service location address application. The provider is prompted to enter the Application Tracking Number (ATN) received at the end of the enrollment/re-enrollment/add alternate service location address process and their last name or business name.



Provider Enrollment Tracking Panel

To Track Provider Enrollment:

Step	Action/Response
1.	Open the Public Web site. Click on www.ctdssmap.com
2.	From the **Provider** menu, click **Provider Enrollment Tracking**. The **Enrollment Tracking Search** panel displays as shown above.
3.	Enter the **ATN** assigned when the provider enrollment was successfully submitted, or the ATN assigned for re-enrollment or when adding an alternate service location address.
4.	Enter the **Business OR Last Name** used for the provider enrollment/re-enrollment.
5.	Click search **search**. The **Search Results** panel displays the search panel with information about the application. The list of status values and their descriptions are found below.

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ATN Status Codes:

Status Code	Status	Description
2	Enrollment Completed	This status indicates that a provider's enrollment application has been approved and fully processed. Providers should await receipt of their Provider Welcome Letter prior to claim submission.
4	Renewal Mailed-Prov to Complete	This status is displayed when the provider has been sent a letter that they are due to re-enroll in the Connecticut Medical Assistance Program. An ATN will remain in this status until Gainwell Technologies receives notification that the application has been completed.
5	Waiting Appl or Info from Prov	This status is used when Gainwell Technologies has returned an incomplete application to a provider, or when Gainwell Technologies is waiting on a provider to submit the supporting documentation to their Web application.
6	Appln Mailed-Prov to Complete	This status is displayed when a provider is granted a Web enrollment exception (i.e., they are permitted to enroll on paper). An ATN will remain in this status until Gainwell Technologies receives the application from the provider.
8	DSS Conducting Initial Review	This status is displayed when an application has passed Gainwell Technologies reviews criteria and has been forwarded to DSS for review. No action is required by the provider when an ATN is in this status.
9	DSS Conducting Final Review	This status is displayed when DSS is conducting their final review of a provider application. No action is required by the provider when an ATN is in this status.
A	DSS Awaiting Info from Prov	This status is displayed when DSS is in the process of reviewing an application and requires some additional information from a provider.
B	Denial Ltr to be Mail to Prov	This status is displayed when an application has been denied and indicates that a letter explaining the reason for denial will soon be mailed to the provider.

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C	ReEnrollment Completed	This status indicates that a provider's re-enrollment application, or their application to add an alternate service location address, has been approved. No further action is required by the provider when an ATN is in this status.
D	Gainwell Rvwing Submitted App	This status is displayed when Gainwell Technologies has received the provider's application and is reviewing the application for completeness. No action is required by the provider when an ATN is in this status.
F	Gainwell Apprvl/Ltr to be Sent	This status is displayed when Gainwell Technologies has approved a provider's application. This status indicates that a provider will soon receive a letter that the application has been completed. No action is required by the provider when an ATN is in this status.
G	DSS Approved/Letter to be Sent	This status is displayed when DSS has approved a provider's application. This status indicates that a provider will soon receive a letter from Gainwell Technologies that the application has been completed. No action is required by the provider when an ATN is in this status.
H	Gainwell Denied	This status is displayed when Gainwell Technologies has denied an application. When an ATN is in this status, a letter has been mailed to the provider to advise the application has been denied.
I	DSS Denied	This status is displayed when DSS has denied an application. When an ATN is in this status, a letter has been mailed to the provider to advise the application has been denied.
J	Pending Validation	This status is displayed by the system when an application is pending validation against the Death Master File (DMF). Each application submitted will have at least one SSN that must be validated against the DMF to meet CMS' and DSS QA's requirements. Once the application's data has been validated, the system will systematically update the ATN to the next appropriate status.
K	Denied-No Resp from Prov/Permt	This status indicates that the application has been denied due to a lack of timely response from a provider. It was also previously used when an application was denied because a

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		resident was not on the hospital's/DPH permit file.
L	DSS Required Info Not Provided	This status indicates that the provider has not supplied all of the required information on their application, and DSS is in the process of reviewing the ATN. No action is required by the provider when an ATN is in this status.
N	Denied - Paper Not Allowed	This status indicates that a provider has submitted a paper enrollment application and is required to use the online Web portal Enrollment Wizard at www.ctdssmap.com.
O	Awaiting Outside Agency Action	This status is used when Gainwell Technologies or DSS is awaiting information from an outside agency, such as the Department of Public Health (DPH), to provide information on behalf of the provider (for example, the Certification and Transmittal form) in order for Gainwell Technologies or DSS to complete the provider's application.
P	OOS Pending Service Approval	This status is used by Gainwell Technologies when a provider completes the enrollment application but approval from DSS' MCCT Unit for out-of-state (OOS) services rendered is pending. No action is required by the provider when an ATN is in this status.
Q	DSS OOS Initial Review	This status is used to indicate to DSS' QA Unit that the application is for an out-of-state (OOS) provider for which services have been approved by DSS' medical review team. No action is required by the provider when an ATN is in this status.
R	Awaiting Attestation Documents	This status is used to indicate the Annual Attestation letter was sent to the provider on February 15th. The provider must submit required documentation annually by June 21st to continue their participation in the Connecticut Medical Assistance Program.
S	DSS Review of Resident App	This status is used to identify those applications that are received for Residents **and** no errors have been detected on the application. As a result, the application is currently being reviewed by DSS' QA Unit. No action is required by the provider when an ATN is in this status.
U	DSS Init Rvw/OIG or Survey Flg	This status is displayed when an application has passed Gainwell Technologies reviews criteria and has been forwarded to DSS for

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		review. This indicates to DSS that either the provider or its owner(s)/board member(s) appear on the federal OIG Sanctions List and/or the provider's response to one or more of DSS' survey questions must be reviewed by DSS. DSS' QA area will review these errors and will then contact the provider if additional information is needed prior to finalizing the application.
V	DSS Init Rvw of OPR Reenroll	This status is displayed when an application for an Ordering, Prescribing, Referring (OPR) provider has passed Gainwell Technologies reviews criteria, and has been forwarded to DSS for review. No action is required by the provider when an ATN is in this status.
W	Awaiting Application Fee	This status is used when an application fee is owed by the provider and the fee has not yet been received. Please note that the fee must be received before any further application processing can occur. Failure to submit this fee in a timely manner will result in dis-enrollment from CMAP for actively enrolled providers.
X	DSS Pending FCBC	This status is used to indicate the application has passed all other screening requirements and now is pending waiting for one, or multiple, owner's fingerprinting/ background checks to be submitted to DSS QA as required by the Affordable Care Act (ACA) provider enrollment/screening requirements.
Y	DSS Suspended	This status is used to indicate that the application has been suspended by DSS' QA Unit, based on a finding under the Affordable Care Act (ACA) provider enrollment/screening requirements. Providers in this status should have received a letter with contact information for the DSS QA Unit, who may be contacted for additional questions.
Z	DSS Attestation with Errors	This status is used to indicate that the application has been returned to the provider due to missing/incorrect information on the Behavioral Health Attestation form. This status is used by DSS QA to trigger a systematic letter to be sent to the provider. The provider has 30 days in which to respond with an updated form. If response is not received timely, ATN will be denied. If the ATN is for a

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		re-enrollment application, the provider will also be disenrolled.

Status	Enrollment/Re-enrollment Information
Approved Enrollment Applications - Web	The Gainwell Technologies Provider Enrollment Unit reviews all enrollment application submissions for completeness and forwards the information to the Department of Social Services' Quality Assurance Unit for approval. The Department of Social Services returns an approval or denial to Gainwell Technologies. If approval is received from the Department of Social Services, the Provider Enrollment Unit then completes the enrollment process in the interChange system for new providers. * **New providers:** Your Medical Assistance Program Provider Manual and Portable Document Format (PDF) Remittance Advice (RA) is available to view, download, and print from our Web portal site: www.ctdssmap.com. The Provider Enrollment Approval Notice notifies the provider of acceptance in the Connecticut Medical Assistance Program(s), as well as the taxonomy/provider type/specialty of the enrolled provider. Providers are then assigned a re-enrollment due date based on the date the application was executed. Refer to Section 3.3 for additional information on re-enrollment procedures and timeframes.
Maintenance of Organization Members	Once enrolled, organizations must use the Secure Web portal to ensure that the performing providers have been added to their organization. The Secure Web portal allows an organization to view, add, or separate members associated with their organization. These updates can only be done by the Secure Web portal account's master user. In order to add members, the member must first enroll in the Connecticut Medical Assistance Program. Members will receive a letter from Gainwell Technologies when any additions or separations are made to their association with the organization. Detailed instructions on using this functionality can be found in Chapter 10 – Web Portal / AVRS of the Provider Manual.

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Status	Enrollment/Re-enrollment Information
Incorrect/Incomplete Web-Based Enrollment Applications	If a provider enrolls through the Web with the Enrollment Wizard, the provider is prompted by the system in real-time to enter the appropriate information to be submitted to complete the enrollment process. Additional information may be needed to complete the Web enrollment process and will be communicated to the provider at the last step in the Enrollment Wizard. The provider must send this paper documentation to complete the enrollment process. The application tracking number (ATN) assigned by the Enrollment Wizard must accompany this paper documentation. Please only send the additionally required documentation. Do not submit a hard copy of the application itself. If any information is missing, invalid, or Gainwell Technologies is unable to process the application, it will be returned to the provider for correction or additional information. Providers will not be able to correct or modify completed applications using the Wizard but instead will need to submit paper corrections.
Denied Enrollment Applications Web	If an enrollment application is denied, a Provider Enrollment/Re-enrollment Rejection Notice is sent to the provider. This letter outlines the reason(s) the application was denied. A provider receiving a denial from the Department of Social Services' Quality Assurance Unit must follow the instructions for responding to the denial as outlined in the letter. In order to reapply to the Connecticut Medical Assistance Program, a provider must once again follow the enrollment process described previously. If your provider type and specialty require an application fee to be paid, a fee is due with this application. Note, the application cannot be processed until either the fee is received or proof of payment to Medicare or another State's Medicaid program can be validated.

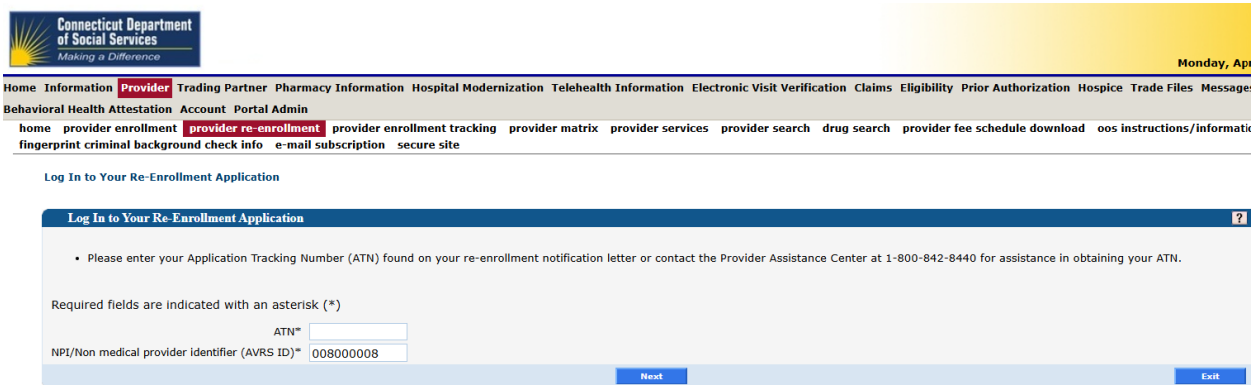
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3.3 Re-enrollment

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Overview

The Internet re-enrollment process begins when the provider receives a letter informing them that it is time to re-enroll. Providers will access their re-enrollment application by logging into their Secure Web portal and entering the Application Tracking Number (ATN) and their NPI or AVRS ID found in this letter on the Log Into Your Re-Enrollment Application from the Provider>Provider Re-Enrollment tab. The provider's existing data is pre-populated on the re-enrollment panels that are presented to the provider. Once the provider validates or modifies the data, the provider clicks the 'Submit' button and the application proceeds through the re-enrollment process. The provider may also be required to submit via mail the appropriate follow-on documentation (FOD) with the ATN for their provider type, e.g., certification, licensure.



Re-enrollment Periods

After initial enrollment, the Department of Social Services requires all providers (organizations, individuals, employed/contracted by an organization providers, and ordering/referring/prescribing providers) to periodically re-enroll in the Connecticut Medical Assistance Program based on pre-defined periods of time. Those time periods differ by taxonomy/provider type/provider specialty. The purpose of re-enrollment is for the Department of Social Services to receive updated information from the provider, including current license and Federal Employer Identification Number (FEIN) information, or changes of address. Most provider re-enrollment notices are systematically generated six (6) months prior to a provider's re-enrollment due date. Provider re-enrollment notices for Long Term Care and ICF/IID providers will systematically be generated eight (8) months prior to a provider's re-enrollment due date. Providers are required to go to the Web portal at www.ctdssmap.com to complete their re-enrollment. Simple step-by-step directions are available through an online tool to assist providers with this process. Providers can also refer to Chapter 10 – Web Portal / AVRS for step-by-step instructions on Web portal enrollment and re-enrollment. Unless noted as an exception in Section 3.2 above, any paper re-enrollment applications received will be denied, with a letter that the provider is required to re-enroll via the Web portal.

If after three (3) months the provider has not re-enrolled or their re-enrollment application has not yet been finalized*, a reminder letter is sent to the provider that they must complete the re-enrollment process prior to their re-enrollment due date. If after this three (3) month period the re-enrollment process is still not completed, the provider will receive a Provider Enrollment/Re-enrollment Rejection Notice.

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Please note that, for Long Term Care and ICF/IID providers, the letter notification process varies slightly in that they will receive an additional notification thirty (30) days prior to their re-enrollment due date that provides additional instructions in accordance with statues regarding the Long-Term Care or ICF/IID provider's responsibility to clients should the Medicaid provider agreement be terminated. However, regardless of provider type, if a provider does not re-enroll by their re-enrollment due date, the provider will be dis-enrolled on that date and will not be able to submit claims for payment for dates of service after that deactivation date.

*Please note that each application, once submitted by the provider, must be processed by Gainwell Technologies and the Department of Social Services' (DSS) Quality Assurance Unit. The application must be submitted to allow adequate time for these processes to occur, which typically takes several weeks to complete.

NOTE: A provider that re-enrolls within six (6) months from deactivation can be re-enrolled with no break in their active status. If a provider does not re-enroll within six (6) months of dis-enrollment, their effective date will be the date the application is received. In exceptional cases, the Department of Social Services will determine the activation date.

Re-enrollment periods for each provider type/specialty can be found using the link below:

Enrollment/Re-enrollment Criteria Matrix

Psychiatric Residential Treatment Facility

This provider type/specialty is required to submit the Annual Psychiatric Residential Treatment Facility Letter by June 21st of each year in order to continue their participation in the Connecticut Medical Assistance Program. For a sample letter, providers may access the W-1688 form available at www.ctdssmap.com by selecting Information, then Publications, and scrolling down to the Provider Enrollment/Maintenance Forms section.

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3.4 Out-of-State Enrollment

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Overview

Out-of-state providers are defined as those providers outside the state of Connecticut, not including border hospitals.

Only duly enrolled providers may receive payment from the Connecticut Medical Assistance Program.

Payment for Medical Assistance Program goods or services furnished to clients while they are out-of-state shall be made by the Department of Social Services to the same extent as payment is made to in-state providers under the following conditions:

- Medical Assistance Program goods or services are needed by a client because a medical emergency occurred while the client was outside of the state.
- Medical Assistance Program goods or services are needed because a client's health would be endangered if required to travel to Connecticut.
- The Department determines that the Medical Assistance Program goods or services are available only in another state and prior authorization was granted to the provider.
- It is general practice for clients in a particular locality of Connecticut to use medical resources in a bordering state. The Department shall allow providers who are designated by the Department to be border providers, to be treated in the same manner as in-state providers.
- Enrollment Application is for the consideration of Medicare Co-insurance or Deductible Claims Reimbursement.
- A child for whom the Department makes adoption assistance or foster care maintenance payment resides outside of Connecticut, or an individual approved to attend school out-of-state who resides in Connecticut.

The enrollment of all other out-of-state providers will be reviewed on a case-by-case basis.

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Program Information

Provider Type	General Information
All Out-of-state Providers	All out-of-state providers that successfully enroll in the Connecticut Medical Assistance Program are eligible to submit claims for clients in the following programs: • HUSKY A • HUSKY B • HUSKY C • HUSKY D
Out-of-state Pharmacy Providers	Pharmacy providers that successfully enroll in the Connecticut Medical Assistance Program are eligible to submit claims for clients in the following programs: • HUSKY A • HUSKY B • HUSKY C • HUSKY D • Connecticut AIDS Drug Assistance Program (CADAP), for dates of service prior to November 1, 2018. For dates of service November 1, 2018, and forward, providers and clients must be enrolled through the Department of Public Health's pharmacy benefit manager, Prime Therapeutics Management LLC. For Prime Therapeutics Management LLC contact information, please reference Chapter 1 - Introduction.

Providers may refer to Chapter 2 - Provider Participation Policy, for more information on provider participation and enrollment.

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Out-of-State Enrollment Process

The process to enroll as an out-of-state Connecticut Medical Assistance Program provider is as follows:

Department of Children and Families (DCF) out-of-state providers rendering services to a Connecticut Medical Assistance Program client, instances where Medicare had made a primary payment with a remaining co-insurance or deductible, and providers with special case agreements, may enroll in the Connecticut Medical Assistance Program using the enrollment/re-enrollment Wizard as instructed for in-state providers above. These out-of-state providers are not required to contact the Provider Assistance Center first to receive approval from the Department of Social Services prior to enrollment/re-enrollment.

All other out-of-state providers may use the enrollment/re-enrollment Wizard if they have received approval from the Department of Social Services. Approval is received by following the preliminary steps outlined below.

Preliminary	Out-of-State Enrollment Information
Contact Provider Assistance Center (PAC)	An Out-of-State Provider may initiate the enrollment process by contacting the Provider Assistance Customer Service Representative (CSR) by telephone. The Provider Assistance Center (PAC) can be reached toll free at 1-800-842-8440, between the hours of 8:00 a.m. – 5:00 p.m. Monday through Friday, excluding holidays. Upon contacting the Provider Assistance Center, a CSR will assist the Out-of-State Provider in determining if the client is eligible for services under the Connecticut Medical Assistance Program for the date of service in question. In order for the CSR to verify client eligibility, the Out-of-State Provider will be asked to provide the following client information: Connecticut Medical Assistance Program Identification # (if available), Client First and Last Name, Date of Birth, Social Security Number. Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information. The number is 1-866-604-3470.
Eligibility Determined	If it is determined that the client is eligible for services under the Connecticut Medical Assistance Program, the Customer Service Representative will direct the Out-of-State Provider to submit their claim and medical summary for the date-of-service for which they wish to enroll to the following: Gainwell Technologies Provider Assistance Center P.O. Box 2991 Hartford, CT 06104 Upon receipt of the claim and medical summary, the Provider Assistance Center will submit the information (as applicable) to the Department of Social Services to determine if the services

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	qualify the provider for participation in the Connecticut Medical Assistance Program.

Submission	Out-of-State Enrollment Information
Claim and Medical Summary Reviewed	Once the Department of Social Services reviews the claim and medical summary, they will either approve or deny the request for consideration of claim payment. If approved, the Provider Assistance Center will forward a letter to the provider instructing the provider to enroll using the Enrollment/Re-enrollment Wizard. If the Out-of-State provider is already enrolled in the CMAP program and the re-enrollment due date falls after the claim date-of-service, then the claim will be submitted for processing. If denied, the provider will be sent a denial letter.
Enrollment Process Web	If approved for enrollment, an Out-of-State provider may then follow the enrollment instructions above, including the submission of an application fee if applicable, for an In-State provider. When submitting an application on the Web, an Out-of-State provider must submit a hard copy of their license. Providers can refer to Section 3.2 of this manual for step-by-step online enrollment instructions.

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3.5 Provider File Maintenance

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Overview

In order to continue participation in the Connecticut Medical Assistance Program, between a provider's enrollment periods the provider must be actively submitting claims and must remain in good standing.

The Department of Social Services will periodically verify:

- that the provider's license remains active and that there is no pending disciplinary action
- that the provider's National Provider Identifier (NPI) and taxonomy information remains active and matches the National Provider Plan and Enumeration System (NPPES)
- that the provider or any of its associated owners, partners, etc. do not appear on the federal sanctions list
- that the provider or any of its associated owners, partners, etc. do not appear on the Social Security Administration's list of deceased individuals
- that an ambulance provider has at least one valid Vehicle Identification Number (VIN) on file
- that a provider has not been added to the Center for Medicare and Medicaid Services' (CMS') adverse actions list

Appropriate action will be taken if any of the above situations are encountered, as outlined below:

Providers with Inactive License	Further review will be conducted and, if a provider cannot supply updated license information, further action, including dis-enrollment and termination of the provider's agreement, will be taken.
Providers with Invalid NPI/Taxonomy Information	Further review will be conducted and, if a provider cannot supply updated NPI or taxonomy information, further action, including dis-enrollment and termination of the provider's agreement, will be taken.
Providers that Appear on the Federal Exclusions List	Providers that appear on the federal exclusions list are not permitted to enroll in the Connecticut Medical Assistance Program. Further action, including disenrollment and termination of the provider's agreement, will be taken.
Providers that Appear on the Social Security Administration's List of Deceased Individuals	Providers that appear on the Social Security Administration's list of deceased individuals will be subject to further action, including dis-enrollment and termination of the provider's agreement. Any of a provider's associated owners or board members appearing on this list will be disassociated from the provider's record.
Ambulance Providers with No Valid VINs	Ambulance providers that do not maintain at least one active VIN will be subject to further action, including dis-enrollment and termination of the provider's agreement.
Providers that Appear on CMS' Adverse Actions List	Providers that appear on the adverse action list are generally not permitted to enroll in the Connecticut Medical Assistance Program. Further action, including dis-enrollment and termination of the provider's agreement, may be taken if a provider is found to have adverse actions reported by Medicare or another State agency.

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It is the provider's responsibility to communicate any changes to their data. Connecticut Medical Assistance Program providers may submit changes to their data on the provider file as explained below.

Notification of Change To Provider Information	Any changes in address, licensure, provider specialty, certification, business name or ownership (Refer to Section 3.6 for information on Ownership Changes), group/Clinic affiliation, and Federal Employer Identification Number (FEIN) of all NPI/non-medical provider identifiers affected must be communicated to DSS. The following sections describe which updates must be made by the provider via the provider's secure Web portal account and which can be submitted in writing on provider letterhead. *Web Portal Updates* All providers will establish Secure Web portal accounts. Once established, all provider data change requests for address updates, member of organization maintenance, and electronic funds transfer (EFT) updates must be made by the provider through the secure provider Web portal at www.ctdssmap.com. Requests received in writing for these types of updates will be returned to the provider.* Please carefully review the instructions regarding address updates that are posted on the secure provider Web portal so as not to negatively impact claims payment if an address is a Person Centered Medical Home (PCMH) site. *Note: If you are a performing provider that has not yet been sent a PIN to create a Secure Web portal account, in order to update your address, please send a signed request on your provider letterhead to Gainwell Technologies at the address or fax number listed further below. *Written Communication* All other types of updates must be submitted in writing to Gainwell Technologies on the provider's letterhead with the provider's signature. The NPI/non-medical provider identifier and taxonomy must be listed on all correspondence. Refer to Chapter 10 – Web Portal / AVRS for more detailed instructions on updates to be made through the secure Web portal.
Address Updates	Some types of changes may require that additional information be attached to the letter. *Change of Address* If a provider is moving its office location, DSS must receive notification of this change in address. If the provider is a licensed facility (such as a clinic) moving to a different location but still using the same license, this requires that a copy of the provider's license be submitted with their address request update. *Expansion of Practice Locations* If an existing provider is opening a new, additional office location, the provider is required to complete an entire application packet

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for that new location. Once approved, the address will be added as an alternate service location to a provider's existing record. To submit this application:

1. From the Home page on the www.ctdssmap.com Web site, select Provider > Secure Site.
2. You must then log on to the Secure Web portal. Once logged on, select Provider > Add Alternate Svc Loc Address.
3. Through a series of screens and prompts, the Wizard will then easily guide you step-by-step through the process to complete the application. As with a re-enrollment application, your existing data will be pre-populated. Once you are on the Alternate Service Location Address panel, you may specify the new location.
4. Upon completion of the Wizard, you will receive an Application Tracking Number (ATN) and will have an opportunity to print a hard copy of the application submitted via the Web. **Please do not send the hard copy to Gainwell Technologies.**
5. Depending on your provider type, there will be some final instructions to complete your application. These instructions may include the submission of additional documentation to Gainwell Technologies, based on the taxonomy/provider type/specialty of the provider. If your provider type and specialty require an application fee to be paid, the application cannot be processed until either the fee is received or proof of payment to Medicare or another State's Medicaid program can be validated. (Note: Out-of-state providers will be required to send in a copy of their license.) Your application cannot be fully processed without the receipt of this supporting documentation. The ATN assigned by the Wizard must accompany this paper documentation.

   PLEASE NOTE: A master Web user can assign clerks to submit an add alternate service location application. If the clerk assigned is associated with multiple AVRS IDs, the clerk will need to utilize the secure Web portal switch provider function to guarantee the application is submitted for the correct AVRS ID.

New Practice Location for a Separately Licensed Site

Maintenance of Organization Members

If a provider's new location has a new license, the provider must complete the entire enrollment process for that location, as indicated in the In-State Enrollment section below. Once approved, a new service location/AVRS ID is created for this provider.

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Failure to Update Information	Organization providers, via the Secure Web portal, can view, add, or separate members associated with their organization. In order to add members, the member must first enroll in the Connecticut Medical Assistance Program. Members will receive a letter from Gainwell Technologies when any additions or separations are made to their association with the organization. Detailed instructions on using this functionality can be found in Chapter 10 – Web Portal / AVRS of the Provider Manual. **Failure to inform Gainwell Technologies of changes may result in the denial of claims, misdirected payments, the loss of provider eligibility, or the recoupment of previously paid claims.** **Entering the new information on a claim form or prior authorization request is not notification of change.**
New NPI/Non-medical Provider Identifier, if needed	Some changes (e.g., a change in ownership or establishment of a new site) require the provider to complete a new provider application or new provider agreement, which may require the issuance of a new NPI/non-medical provider identifier. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. In the instance of the issuance of a new non-medical provider identifier, it is important to note that the format of the provider number may vary from the previous number. In the instance of a merger, the provider must complete a new provider application or provider agreement, as indicated above. It is very important that a provider indicate, via a letter to Gainwell Technologies, which NPI/non-medical provider identifier will no longer be a valid billing provider. Note: In the instance of a change of ownership for a long-term care provider, the new owner will always inherit the previous owner's AVRS ID. However, the new owner's NPI will be assigned to the existing AVRS ID.
Where to Send Changes To Provider Information	Send all changes to the provider's file described above to: Gainwell Technologies Provider Enrollment Unit P.O. Box 5007 Hartford, CT 06102-5007 Or you may fax your signed request on your provider letterhead to 1-877-899-5401.
Incorrect Change Requests	If a written request contains incorrect or missing information or is a change that must be made via the provider's secure Web portal account, the original written request is returned to the provider with a request to supply the missing or corrected information, or to update that information via the secure Web portal.

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How to Obtain Ongoing Program Updates via Email Notifications	To ensure timely notification of ongoing program updates, providers and their office staff must subscribe for e-mail notifications and maintain their subscriptions via the www.ctdssmap.com Web site, by selecting Provider > E-mail Subscription from the drop-down menu. Providers may refer to Chapter 10 - Web Portal / AVRS for more information on subscribing for email notifications and maintaining those subscriptions. DSS no longer distributes paper provider bulletins to providers.

Providers may refer to Chapter 2 - Provider Participation Policy, for more information on provider participation and enrollment.

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3.6 Provider Ownership Changes

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Overview

Providers are required to notify DSS Enrollment and Quality Assurance (QA) of all ownership changes and updates. Failure to notify DSS PRIOR to the change will lead to possible claims recoupment and/or denial for the period between the date of change and notification to DSS and QA. This requirement is stated in the CT Medical Assistance Program (CMAP) Provider Agreement that all providers sign during enrollment, re-enrollment and is included in the Provider Manual (Chapter 2, Section 17b-262-526, section 9).

Changes that require DSS notification include:	• Provider Sales • Board Changes • Stock Purchases • Change in Ownership %
For all providers except Long-Term Care Facilities (LTC/ICF-IDD):	• All changes in ownership by sale, stock exchange/purchase or board replacement require a new provider enrollment application. • All changes in ownership will require an enrollment that starts effective the date of the bill of sale. • All changes in ownership require a notarized letter on company letter head from the previous ownership detailing the sale and date when their enrollment with CMAP/CT Medicaid will end. • CT Medicaid ID's (AVRS IDs) cannot be part of the sale. • All new enrollments due to ownership sales or stock changes must obtain a new NPI
For Long-Term Care Facilities (LTC/ICF-IDD) Providers:	• LTC/ICF-IID providers must maintain the same AVRS ID (Medicaid ID) and must call the Provider Assistance Center (PAC) at 1-800-842-8440 to obtain a new re-enrollment ATN.
Who to send notification of ownership changes to:	Notification can be sent to ctproviderenrollment@gainwelltechnologies.com and to Nicole Sinisgalli at DSS QA Nicole.Sinisgalli@ct.gov.

Link to Important Message (IM) regarding Ownership Changes: Important Reminder Concerning Ownership Changes

Link to Provider Bulletin 2025-09: PB 2025-09 IMPORTANT REMINDER Concerning Ownership Changes

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