Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

The purpose of this document is to outline the following:

1) Whether providers are required to enroll/re-enroll via the Web portal
2) Additional follow on documentation that providers must submit in order to complete their provider enrollment/re-enrollment/add alternate service location address application, if applicable
3) Re-enrollment periods for each provider type/specialty
4) License requirements for each type/specialty, with additional instructions below:

- **In-state Providers:** Licensed through Connecticut's Department of Public Health (DPH) – If a provider type/specialty is licensed through DPH, in order to enroll/re-enroll/add alternate service location address with that type/specialty, the provider's license must be active and must be a license type indicated in the "DPH License Type" column below. A blank in the DPH License Type column indicates that either the provider type/specialty is licensed through another State Agency, such as the Department of Children and Families (DCF), or that there are no license requirements for that type/specialty.
- For definitions of the DPH license types found in the last column or the tables below, reference APPENDIX A – License Type Definitions.
- **Out-of-state Providers:** Out-of-state providers must provide a hard copy of their license that contains their license number, license effective date, and license end date. Between a provider's enrollment/re-enrollment period, if an out-of-state provider's license is nearing its expiration date, providers will be required to submit updated license information in order to remain actively enrolled in the Connecticut Medical Assistance Program.

Web Portal Enrollment/Re-enrollment/Add Alternate Service Location Address Applications with No Additional Follow on Documents

The following provider types/specialties are required to enroll/re-enroll/add alternate service location address on the Web portal. These provider types/specialties have no additional follow on documents.

Provider Type/Specialty Description	Provider Type/ Specialty	Re-enrollment Period	DPH License Type
Hospitals/ Inpatient^	01/001	60 months	GH, CH
Hospitals/ Long Term or Chronic Disease Hospital – Inpatient	01/005	60 months	CDH, PSY
Hospitals/ Outpatient^	01/007	60 months	GH, CH
Hospitals/ Long Term or Chronic Disease Hospital – Outpatient^	01/019	60 months	CDH
Residents - Medical***	02/700	36 months	1
Residents – Dental ***	02/701	36 Months	2
Residents – Podiatry ***	02/702	36 Months	19
Extended Care Facility/Chronic - Inpatient +	03/005	60 months	CCNH, CDH, PSY
Extended Care Facility/Chronic & Convalescent Nursing Homes and Rest Homes with Nursing Supervision ****	03/030	60 months	CCRH
Extended Care Facility/ Chronic & Convalescent Nursing Home ****	03/035	60 months	CCNH
Extended Care Facility/ Skilled Nursing Facility *****	03/041	60 months	CCNH
Extended Care Facility/Rest Homes with Nursing Supervision	03/042	60 months	RHNS
FQHC Physician Services – Non-mental Health	08/527	24 months	OPC
FQHC Physician Services – Mental Health	08/528	24 months	OPC
Advanced Practice Nurse/All Specialties	09/ALL	60 months	12
School Based Child Health	12/120	36 months	
Special Services/Pvt Non-Medical Institution Billing Provider	12/580	60 months	
Special Services/Pvt Non-Medical Institution Performing Provider	12/581	60 months	
Podiatrist	14/140	60 months	19
Chiropractor	15/150	60 months	7
Therapist/Physical Therapist	17/170	60 months	14
Therapist/Occupational Therapist	17/171	60 months	48
Therapist/Audiologist Therapist	17/173	60 months	17

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Provider Type/Specialty Description	Provider Type/ Specialty	Re-enrollment Period	DPH License Type
Therapist/Speech Therapist	17/176	60 months	18
Optometrist	18/180	60 months	3
Optician	19/190	60 months	38
DME/Medical Supply Dealer/Medical and Surgical Supplies^	25/248	24 months	
DME/Medical Supply Dealer/Durable Medical Goods^	25/249	24 months	
DME/Medical Supply Dealer^ >	25/250	24 months	
DME/Medical Supply Dealer/Orthotic And Prosthetic Devices^	25/277	24 months	
Transportation Broker	26/268	60 months	
Non-emergency Livery/Taxi	26/561	60 months	
Wheelchair Van (Non-emergency Invalid Coach)	26/562	60 months	
Transportation Network Company	26/565	60 months	
Physician/All Specialties	31/ALL	60 months	1, 9
Nurse Midwife	32/095	60 months	16
Behavioral Health Clinician/Psychology	33/112	60 months	8
Behavioral Health Clinician/Licensed Clinical Social Worker	33/115	60 months	58
Behavioral Health Clinician/Licensed Certified Alcohol & Drug Counselor	33/118	60 months	44, 45
Behavioral Health Clinician/Marital and Family Therapist	33/119	60 months	27
Behavioral Health Clinician/Professional Counselor	33/121	60 months	46
Acupuncturist *Reserved for future use	42/402	60 months	43
Community First Choice	50/502	60 months	
BHH/TCM/Waiver Billing Provider - MFP - IFS/Comp Waiver Biller	53/529	60 months	
BHH/TCM/Waiver Billing Provider - FI MFP – IFS/Comp Waiver Biller	53/530	60 months	
BHH/TCM/Waiver Billing Provider - DDS Comp Waiver Biller	53/531	60 months	
BHH/TCM/Waiver Billing Provider - DDS IFS Waiver Biller	53/532	60 months	
BHH/TCM/Waiver Billing Provider - Employment and Day Support Waiver Billing Provider	53/534	60 months	
BHH/TCM/Waiver Billing Provider – DMHAS TCM	53/545	60 months	
BHH/TCM/Waiver Billing Provider – DMHAS BHH	53/546	60 months	
BHH/TCM/Waiver Performing Provider – DDS Performing	54/533	36 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type/Specialty Description	Provider Type/ Specialty	Re-enrollment Period	DPH License Type
Provider			
Home/Community Based Provider – Assisted Living Service Agency	57/542	60 months	ALSA
Naturopath	62/355	60 months	5
Naturopath Group	65/355	60 months	
Chiropractor Group	68/150	60 months	
Advanced Practice Nurse Group	70/ALL	60 months	
Nurse Midwife Group	71/095	60 months	
Physician Group	72/ALL	60 months	
Podiatrist Group	73/140	60 months	
Optometrist Group	74/180	60 months	
Optician Group/Optical Shop******	75/190	60 months	
Autism Specialist Group	80/405	24 months	
Acupuncture Group *Reserved for future use	82/402	60 months	
Behavioral Health Clinician Group/Psychology	86/112	60 months	
Behavioral Health Clinician Group/Licensed Clinical Social Worker	86/115	60 months	
Behavioral Health Clinician Group /Licensed Certified Alcohol & Drug Counselor	86/118	60 months	
Behavioral Health Clinician Group /Marital and Family Therapist	86/119	60 months	
Behavioral Health Clinician Group /Professional Counselor	86/121	60 months	
Therapist Group/Physical Therapist	87/170	60 months	
Therapist Group/Occupational Therapist	87/171	60 months	
Therapist Group/Speech Therapist	87/176	60 months	
State Institution - ICF/IID (Non Bed Count Specific) ****	90/038	60 months	
Physician Assistant/Medical Physician Assistant**	97/995	60 months	23
Physician Assistant/Surgical Physician Assistant**	97/996	60 months	23
Physician Assistant/Primary Care Physician Assistant**	97/997	60 months	23

* Reserved for future use - (Providers cannot enroll in this provider type/specialty at this time. Notification will be published when enrollment can begin.)

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

**For those providers that are enrolling as an OPR, verification that the supervising physician is associated to the same group as the PA is not required. Verification is only needed to confirm the supervising physician is a currently enrolled Medicaid Provider.
***Out-of-state residents are not permitted to enroll.
****Follow on Documents are not required as part of the enrollment or re-enrollment process. A Certification & Transmittal (C&T) must be submitted on an annual basis by DPH in order to remain enrolled in CMAP.
*****Follow on Documents are not required as a part of the enrollment or re-enrollment process. A Certification & Transmittal (C&T) must be submitted on an annual basis by DPH in order to remain enrolled in CMAP. Only providers approved by the Department of Social Services may enroll in this provider type and specialty.
******An Optical Shop is required to employ at least one licensed Optician. In addition, the Optician must be enrolled in CMAP and associated to the Optical Shop.
+ New providers no longer allowed enrollment in this Provider Type/Specialty
^Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).
>For all Out-of-State DME providers, enrollment is usually restricted to Medicare Crossover Claims only

Web Portal Enrollment/Re-enrollment/Add Alternate Service Location Address Applications with Additional Follow on Documents

The following provider types are also required to enroll/re-enroll/add alternate service location addresses on the Web portal. These provider types have follow on document requirements. Those documents are listed by provider type/specialty below.

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
HOSPITAL	01/001	Inpatient (Out-of-State only)	• Copy of current general hospital license Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	
	01/002	Psychiatric/ Inpatient under 21	• Copy of medical director's current physician license • *Out of state providers only:* in addition to the above criteria, copy of current license as a Hospital for Mentally Ill Persons Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	PSY
	01/003	Psychiatric /Inpatient 21-64	• Copy of medical director's current physician license • *Out of state providers only:* in addition to the above criteria, copy of current license as a Hospital for Mentally Ill Persons NOTE: This type and specialty is restricted to bill for Medicare Crossover Claims only. Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	PSY

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	01/004	Psychiatric/ Inpatient 65+	• Copy of medical director's current physician license • *Out of state providers only:* in addition to the above criteria, copy of current license as a Hospital for Mentally Ill Persons Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	PSY
	01/007	Outpatient (Out-of-State only)	• Copy of current general hospital license Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	
	01/008	Psychiatric – Outpatient	• Copy of medical director's current physician license • *Out of state providers only:* in addition to the above criteria, copy of current license as a Hospital for Mentally Ill Persons Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	PSY
	01/010	Intermediate Duration Acute Psychiatric Care	• Provider must currently be enrolled in the Connecticut Medical Assistance Program as an Acute Care Hospital - Inpatient (01/001). • Copy of current DMHAS certification for Intermediate Psychiatric Care (ICC) beds	60 months	GH, CH

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	01/018	Birth Center	• Out-of-state Hospitals – copy of license • Accreditation by the Commission for the Accreditation of Birth Centers • Be licensed by the Department of Public Health as a maternity hospital in accordance with section 19-13-D14 of the Regulations of Connecticut State Agencies or be licensed by the Department of Public Health as a birth center in accordance with regulations adopted by the Department of Public Health that specifically regulate birth centers; and • Comply with (A) section 19a-505 of the Connecticut General Statutes and (B) section 19-13-D14 of the Regulations of Connecticut State Agencies or such other regulations adopted by the Department of Public Health that specifically regulate birth centers.	60 months	MAT
	01/019	Long Term or Chronic Disease Hospital - Outpatient (Out-of-State only)	• Copy of current general hospital or long term care hospital license Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	
	01/086	Dental Clinic	• Copy of Dental Director's current dental license • Statement from Dental Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document)	60 months	GH, CDH, CH
EXTENDED CARE FACILITY	03/038	ICF/IID (Non Bed Count Specific)	• Copy of the Department of Developmental Services (DDS) license pursuant to section 17a-227 of the Connecticut General Statutes • A Certification & Transmittal (C&T) must be submitted on an annual basis through DPH in order to remain enrolled in CMAP.	60 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	03/All	OOS LTC Providers (Crossovers Only)	• Copy of current license • Medicaid rate letter from their state • Signed Nursing Facility Provider Agreements (2 copies) • Note: These providers do not complete an entire enrollment packet. In addition to the documentation above, the provider is required to complete the first two pages of the provider application along with a W-9 form	60 months	
HOME HEALTH AGENCY	05/050	Home Health Agency	• Home Health Agency Designation of Service Areas (W-1005) Form (standard form provided by DXC Technology as part of the provider's follow on document) Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	HHC

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
CLINIC	08/020	Ambulatory Surgical Center (ASC)	• Copy of current DPH license as an Outpatient Surgical Facility • Where applicable, current Outpatient Clinic license must reference CT Public Health Code Sections 19-13-D54 and 19a-116-1 (approval to provide abortion services) • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics, if any, and current DPH license for each site • Description of the services provided Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	ASC
	08/040	Rehabilitation Facility	• Copy of CARF or JCAHO accreditation • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics • Description of the services provided	24 months	
	08/045 * (Reserved for future use)	Urgent Care Clinic (UCC) *(Reserved for future use)	• Copy of current DPH license as an Urgent Care Center • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow-on-document) • Description of services provided **Out-of-state providers: Copy of current license**	36 months	OPC

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/081	Rural Health Clinic (RHC)	• Copy of current DPH license as an Outpatient Clinic • Where applicable, current Outpatient Clinic license must reference CT Public Health Code Sections 19-13-D54 and 19a-116-1(approval to provide abortion services) • Documentation of CMS designation as Rural Health Clinic • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of the services provided	24 months	OPC
	08/083	Family Planning Clinic	• Copy of current DPH license as an Outpatient Clinic • Where applicable, current Outpatient Clinic license must reference CT Public Health Code Sections 19-13-D54 and 19a-116-1(approval to provide abortion services) • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of the services provided	24 months	FP
	08/085	PCMH Primary Care Clinic	• Copy of current DPH license as an Outpatient Clinic • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • Description of the services provided	24 months	FP

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/088	Pediatric Clinic	• Copy of current DPH license as an Outpatient Clinic • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of the services provided	24 months	OPC
	08/096	Methadone Clinic	• Copy of current DPH license as a Facility for the Care or Treatment of Substance Abusive or Dependent Persons (Chemical Maintenance Treatment) • Copy of facility's DEA Controlled Substance Registration Certificate • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • For initial enrollment only, complete Mental Health and Substance Abuse Questionnaire (provided by DXC Technology as part of the provider's follow on document)	24 months	SA

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/300	Free-standing Renal Dialysis Clinic	• Copy of current DPH license as an Outpatient Dialysis Unit • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	HEMO
	08/519	School Based Health Center	• Copy of Department of Public Health (DPH) license as an Outpatient Clinic (please note that you must provide primary care services and, in order to bill for behavioral health services, mental health services must be included as approved services provided by the site under the DPH Outpatient Clinic license). • Copy of Medial Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of services provided	24 months	OPC

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Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
CLINIC (FQHC)	08/520	Dental FQHC	• Copy of Department of Public Health (DPH) license as an Outpatient Clinic • Copy of USPHS (United States Public Health Services) grant letter for each site • If FQHC look-alike, a copy of the CMS approval letter for each site • Copy of Dental Director's current dental license • Statement from Dental Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics, if any, and current DPH license for each site • Description of the services provided • Count of patient treatment staff by discipline	24 months	OPC
	08/521	Medical FQHC	• Copy of Department of Public Health (DPH) license as an Outpatient Clinic • Where applicable, current Outpatient Clinic license must reference CT Public Health Code Sections 19-13-D54 and 19a-116-1(approval to provide abortion services) • Copy of USPHS (United States Public Health Services) grant letter for each site • If FQHC look-alike, a copy of the CMS approval letter for each site • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics, if any, and current DPH license for each site • Description of the services provided	24 months	OPC

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/521	Medical Federally Qualified Health Center (FQHC) Clinics for Tribal Health Medical Facility	Tribal Health Services have the following requirements: • Copy of Medical Director's current physician license • Statement from Medical Director accepting full responsibility for services (standard form provided by DXC Technology as part of the provider's follow on documents) • Copy of certificate of liability insurance • A list of satellite clinics (if applicable) • A description of the services provided • Addendum to Provider Enrollment Agreement for Tribally-Operated Indian Health Service Facilities (standard form provided by DXC Technology) • Executed contract between the tribal health facility and the Department of Health and Human Services, Indian Health Service	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/522	Behavioral Health FQHC	• Copy of current DPH license for mental health services: Psychiatric Outpatient Clinic (Outpatient and / or day or evening treatment) **OR** copy of DPH current license for substance abuse services: Facility for the Care or Treatment of Substance Abusive or Dependent Persons (Outpatient and / or day or evening treatment) • Copy of USPHS (United States Public Health Services) grant letter for each site • If FQHC look-alike, a copy of the CMS approval letter for each site • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics, if any, and current DPH license for each site • Description of the services provided • For initial enrollment only, complete Mental Health and Substance Abuse Questionnaire (provided by DXC Technology as part of the provider's follow on document)	24 months	OPC, POCA
	08/523	Medical Clinic	• Copy of current DPH license as an Outpatient Clinic • Where applicable, current Outpatient Clinic license must reference CT Public Health Code Sections 19-13-D54 and 19a-116-1(approval to provide abortion services) • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of the services provided	24 months	OPC, INF

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Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/524	Free-standing Dental Clinic (Standalone)	• Copy of current DPH license as an Outpatient Clinic • Copy of Dental Director's current dental license • Statement from Dental Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics, if any, and current DPH license for each site • Description of the services provided • Count of patient treatment staff by discipline	24 months	OPC
	08/525	Behavioral Health Clinic or Behavioral Health Clinic Outpatient Psychiatric Clinics for Children	• Copy of current DPH license for mental health services: Psychiatric Outpatient Clinic (Outpatient and/or day or evening treatment) **OR** copy of current DPH license for substance abuse services: Facility for the Care or Treatment of Substance Abusive or Dependent Persons (Outpatient and/or day or evening treatment) • If provider is not licensed through DPH, a copy of current DCF license for Outpatient Psychiatric Clinic for Children • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH or DCF license for each site • Description of the services provided • For initial enrollment only, complete Mental Health and Substance Abuse Questionnaire (provided by DXC Technology as part of the provider's follow on document)	24 months	POCA, SA if licensed through DPH; Note that these providers may also be licensed through DCF.

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Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	08/526	Enhanced Care Clinic (ECC)	• Copy of current DPH license for mental health services: Psychiatric Outpatient Clinic (Outpatient and/or day or evening treatment) **OR** copy of current DPH license for substance abuse services: Facility for the Care or Treatment of Substance Abusive or Dependent Persons (Outpatient and/or day or evening treatment) • If provider is not licensed through DPH, a copy of current DCF license for Outpatient Psychiatric Clinic for Children • Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of the services provided • A signed copy of the Designation as an Enhanced Care Clinic Agreement • For initial enrollment only, complete Mental Health and Substance Abuse Questionnaire (provided by DXC Technology as part of the provider's follow on document)	60 months	POCA, SA if licensed through DPH; Note that these providers may also be licensed through DCF.

SPECIAL SERVICES	12/033	Psychiatric Residential Treatment Facility	• Copy of current attestation letter that includes the following information:
			  • Facility General Characteristics: name, address, telephone number of the facility, and a State provider identification number or "L" number (e.g., 07LXXX);
			  • Facility Specific Characteristics:
			  (a) bed size;
			  (b) number of individuals currently served within the PRTF who are provided service based on their eligibility for the Medicaid inpatient psychiatric services for individuals under age 21 benefit (Psych under 21)
			  (c) number of individuals, if any, whose Medicaid Psych under 21 benefit was paid for by any State other than the State identified in the PRTF's
				60 months	Note: In-state providers must be licensed through DCF.

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Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
			attestation letter during the most recent state fiscal year; and (d) identify by listing all the States from which the PRTF has ever received Medicaid payment for the provision of Psych under 21 services. • A statement certifying that the facility currently meets all of the requirements of 42 CFR Part 441, Subpart D "Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs" and 42 CFR Part 483, Subpart G "Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21". • A statement acknowledging the right of the State Survey Agency (or its agents) and CMS to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences. • A statement that the facility will submit a new attestation of compliance annually and in the event a new facility director is appointed. • The signature of the facility director. • The date the attestation was signed. • Copy of current accreditation by JCAHO, CARF, Council on Accreditation of Services for Families and Children, or by any other accreditation organization, with comparable standards (subject to determination by the Department) If an Out-of-state provider • Current copy of home state Medicaid recognition as a PRTF or documentation that state of residence does not offer inpatient facility services for those under age 21; and Current copy of approval letter from Department of Children and Families (DCF), recognizing the facility as a PRTF servicing Connecticut children.		

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
SPECIAL SERVICES	12/511	Mental Health Group Homes	• Copy of current DMHAS certification as a Mental Health Group Home Provider of Rehabilitative Services	36 months	MHCR, MHRL
	12/583	Birth to Three Billing Provider	• Copy of the provider's signed contract with the Office of Early Childhood (OEC).	60 Months	
	12/585	Community Services	• Special authorization required from DSS. Provider needs DSS approval before the provider can continue the enrollment process. • Description of the services provided	36 months	GH, PSY, if licensed through DPH; Note that these providers may also be licensed through DCF if treating clients 18 and under
LOCAL HEALTH DEPARTMENTS	22/202	Local Health Departments	• Copy of the Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document)	60 months	
PHARMACY	24/240	Pharmacy	• Copy of current Connecticut retail pharmacy license • For newly enrolling, in-state providers: Place a check on the line in the FOD to confirm you have the capacity to participate in the program's on-line point of sale and prospective drug use claims processing. (Not applicable to out-of-state pharmacies providing only out-of-state services to clients in authorized circumstances). **Please include the FOD coversheet with all documents returned.** • If a change of ownership, a bill of sale or similar document of proof of ownership is required as part of the application process. • For out-of-state pharmacy rendering service in Connecticut:	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
			• Copy of current retail pharmacy license in home state • Copy of current Certificate of Registration from the Connecticut Department of Consumer Protection • Toll free telephone number disclosed on labels for drugs dispensed in Connecticut For out-of-state pharmacies rendering service out of Connecticut only to clients in authorized circumstances: statement on company letterhead verifying that no services are provided in Connecticut.		

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
DME/MEDICAL SUPPLY DEALER	25/220	Hearing Aid Dealer	• Copy of current Hearing Aid Dealer license **OR** current Audiologist license	24 months	17, 37
TRANSPORTATIO N PROVIDER	26/260	Ambulance	• In-state providers: o If a provider has indicated they are enrolling to provide paramedic intercept services only: Copy of current contract with paramedic intercept provider • Out-of-state providers: o Copy of license o Copy of current state fee schedule/schedule of rates o Copy of the agreement between the Advanced Life Support (ALS) and Basic Life Support (BLS) ambulance company that indicates the paramedic services can be provided.	60 months	FR, SR, C and L
	26/261	Air Ambulance	• Copy of current FAA Air Carrier Certificate • Out-of-state providers: Copy of Air Ambulance Service license. License must be from state that matches the provider's primary service location address state.	24 months	L
	26/262	Critical Care Helicopter	• Copy of current FAA Air Carrier Certificate • Out-of-state providers: Copy of Air Ambulance Service license. License must be from state that match provider's primary service location address state.	24 months	L

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
DENTIST/ DENTIST GROUPS	27/270 76/270	Endodontist	• Out-of-state providers: Copy of current license • Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification: ○ Documentation of a Master of Dental Science degree from an academic institution in Endodontics ○ Certificate from a residency program confirming the successful completion of the endodontic residency ○ Certificate describing Board Certification in Endodontics **OR** Certificate describing Board Eligibility for Endodontic (This is not required, but beneficial.) • Copy of malpractice insurance Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/270: 2
	27/271 76/271	General Dentistry Practitioner	• Out-of-state providers: Copy of current license • Copy of malpractice insurance • Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/271: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type

	27/272
	76/272
		Oral and Maxillofacial Surgeon	• Out-of-state providers: Copy of current license
			• Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification:
			  ○ Documentation of a Master of Dental Science degree from an academic institution in Oral and Maxillofacial Surgery
			  ○ Documentation of a M.D. Medical Doctor degree from a medical school
			  ○ Certificate from a residency program confirming the successful completion of the OMFS residency
			  ○ Certificate describing Board Certification in OMFS **OR** Certificate describing Board Eligibility for OFS (This is not required, but beneficial.)
			• Copy of current malpractice insurance
			• Copy of current Conscious Sedation License
			• Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance
				24 months	For 27/272: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	27/273 76/273	Orthodontist	• Out-of-state providers: Copy of current license • For initial enrollment or after a 5 year lapse in enrollment please provide the following for verification: o Masters Degree in Orthodontia, or o Certificate from a residency program confirming the successful completion of the Orthodontia residency, or: o DSS will validate the presence of the following documentation: Completion of an American Dental Association accredited post graduate continuing education course consisting of a minimum of two (2) years of orthodontic seminars, and/or submitting three (3) completed case histories with a comparable degree of difficulty as those cases meeting the Department's requirements per the Connecticut State Statutes if requested by the DSS orthodontic consultant. • If DSS fails to receive the above information, DSS will send a letter to the provider requesting this information be sent to the Director of the Dental Department. • Copy of malpractice insurance • For initial enrollment or after a 5 year lapse in enrollment please provide one of the following for verification o Certificate describing Board Certification in Orthodontia **OR**; Certificate describing Board Eligibility for Orthodontia (This is not required, but beneficial.) Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/273: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type

	27/274
	76/274
		Pediatric Dentist (Pedodontist)	• Out-of-state providers: Copy of current license
			• Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification:
			  ○ Certificate from a residency program confirming the successful completion of the pediatric dentistry residency
			  ○ May have an alternate route to certification where the Dental Consultant reviews three (3) completed cases and approves the pediatric dentist to provide orthodontic services
			• Certificate describing Board Certification in Pediatric Dentistry **OR** Certificate describing Board Eligibility for Pediatric Dentistry (This is not required, but beneficial.)
			• Copy of malpractice insurance
			• Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance
				24 months	For 27/274: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	27/275 76/275	Periodontist	• Out-of-state providers: Copy of current license • Verification of specialty credentials only needs to complete at the initial enrollment or after 5 years lapse in enrollment. Please provide one of the following for verification: o Certificate from a residency program confirming the successful completion of the Periodontics residency **OR** may have a Master of Dental Science degree from an academic institution in Periodontics o Certificate describing Board Certification in Periodontics **OR** Certificate describing Board Eligibility for Periodontics (This is not required, but beneficial.) • Copy of malpractice insurance Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/275: 2
	27/276 76/276	Oral and Maxillofacial Pathologist	• Out-of-state providers: Copy of current license • Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification: o Documentation of a Master of Dental Science degree from an academic institution in Oral Pathology o Certificate from a residency program confirming the successful completion of the OMP residency • Certificate describing Board Certification in OMP **OR** Certificate describing Board Eligibility for OMP (This is not required, but beneficial.) • Copy of malpractice insurance Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/276: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	27/278 76/278	Dental Hygienist	• Verification of employment as a licensed dental hygienist for at least 2 years. The documentation does not have to indicate continuous employment. The documentation may or may not be from the hygienist's current employer, as applicable. • Verification of current employment in a public health facility. It is to be submitted on the employer's letterhead and signed by the employer. The letter is also to identify the type of public health facility and is to include a statement that the applicant's place of employment does not have a dental group on site. • Copy of malpractice insurance Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/278: 13
	27/293 76/293	Oral and Maxillofacial Radiologist	• Out-of-state providers: Copy of current license • Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification o Documentation of a Master of Dental Science degree from an academic institution in Oral and Maxillofacial Radiology o Certificate from a residency program confirming the successful completion of the OMR residency • Certificate describing Board Certification in OMR **OR** Certificate describing Board Eligibility for OMR (This is not required, but beneficial.) • Copy of current malpractice insurance • Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/293: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	27/294 76/294	Public Health Dentist	• Out-of-state providers: Copy of current license • Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification: ○ Documentation of the successful completion of a Master's of Public Health Degree from a School of Dental Medicine or higher education institution • Copy of malpractice insurance • Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance	24 months	For 27/294: 2

	27/295
	76/295
		Prosthodontist	• Out-of-state providers: Copy of current license
			• Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification:
			  ○ Documentation of a Master of Dental Science degree from an academic institution in Prosthodontics
			  ○ Certificate from a residency program confirming the successful completion of the Prosthodontics residency
			• Certificate describing Board Certification in Prosthodontics **OR** Certificate describing Board Eligibility for Prosthodontics (This is not required, but beneficial.)
			• Copy of malpractice insurance
			• Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance
				24 months	For 27/295: 2

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type

	27/296
	76/296
		Dental Anesthesiologist	• Out-of-state providers: Copy of current license
			• Verification of specialty credentials only needs to be completed at the initial enrollment or after a 5 year lapse in enrollment. Please provide one of the following for verification:
			  ○ Documentation of a Master of Dental Science degree from an academic institution in Anesthesiology
			  ○ Certificate from a residency program confirming the successful completion of the Anesthesiology residency
			• Certificate describing Board Certification in Anesthesiology **OR** Certificate describing Board Eligibility for Anesthesiology (This is not required, but beneficial.)
			• Copy of malpractice insurance
			• Note: If the provider is enrolling as an in-state OPR, there are no Follow on Documents required. OOS providers must still submit a copy of current license and proof of malpractice insurance
				24 months	For 27/296: 2, 22

LABORATORY	28/280	Independent Lab	• Copy of current license For out-of-state laboratories providing services to clients in CT, a copy of the current license in home state. If no license is required to operate in the home state and all other requirements for enrollment in the CMAP are met, the provider can submit documentation that the laboratory is an active Medicaid provider in the home state.	60 months	
RADIOLOGY	29/290	Non-portable Radiology	• FDA Mammography Certificate, is required if the following question on Application is answered, "Yes:" Do you perform mammography's?	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	29/291	Portable Radiology	• FDA Mammography Certificate, is required if the following question on Application is answered, "Yes:" Do you perform mammography's?	24 months	
PERSONAL CARE SERVICES	36/361	Personal Care – Agency	• Copy of provider's contract with DSS	60 months	
	36/362	PCA Service Provider	• Copy of credentialing document from Allied	24 months	
	36/363	Personal Care – PCA Fiscal Intermediary	• Copy of provider's contract with DSS in place of the Provider Agreement	60 months	
AUTISM SPECIALIST	40/405	Board Certified Behavior Analyst	• Copy of board certification as a Behavioral Analyst, as issued by the Behavior Analyst Certification Board • Copy of Approval Letter issued by Beacon Health Options, as a Behavioral Health Services Provider in their Autism Division • Out-of-state providers - a copy of a license as a Behavior Analyst, or other documentation showing approval to provide these services within your State	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
DRUG and ALCOHOL ABUSE CENTER	63/001	Inpatient	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • Description of the services provided	24 months	SA if licensed through DPH; Note that these providers may also be licensed through DCF if treating clients 18 and under.
	63/007	Outpatient	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics and current DPH license for each site • Description of the services provided • For initial enrollment only, complete Mental Health and Substance Abuse Questionnaire (provided by DXC Technology as part of the provider's follow on document)	24 months	SA if licensed through DPH; Note that these providers may also be licensed through DCF if treating clients 18 and under.
MENTAL HEALTH WAIVER BILLING PROVIDER	77/770	MH Waiver FI	• Copy of signed contract with DMHAS	60 months	
	77/771	MH Waiver Service Provider	• Copy of credentialing letter issued by Advanced Behavioral Health (ABH)	24 months	
	77/772	MH Assisted Living	• Copy of credentialing letter issued by Advanced Behavioral Health (ABH)	60 months	ALSA

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
HOSPICE AGENCY	79/060	Hospice	• Copy of current license • Home Health Agency Designation of Service Areas (W-1005) Form (standard form provided by DXC Technology as part of the provider's follow on document) • The HHC license must list Hospice as a service provided by the Home Health Care Agency. (Under the "To provide the following Home Health Care Services:" section) Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	60 months	HHC, HSPC

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
STATE INSTITUTIONS	90/002	Psychiatric/ Inpatient under 21	Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP). • Copy of the medical director's current physician license **OR** • All of the following requirements: ○ Copy of current accreditation by JCAHO, CARF, Council on Accreditation of Services for Families and Children, or by any other accrediting organization, with comparable standards (subject to determination by the Department) ○ A statement acknowledging the right of the Department of Public Health (DPH) to conduct unannounced on-site surveys ○ A statement from the facility stating the number of beds, number of Medicaid clients, and a list of states that have paid the facility for Medicaid clients ○ A copy of current Attestation Letter indicating compliance with Federal Rule 66FR 7148 "Inpatient psychiatric facility services for individuals under age 21-Condition of participation-Use of restraint and seclusion" ○ A statement that the facility will submit a new attestation of compliance when a new facility director is appointed.	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	90/003	Psychiatric/ Inpatient 21-64	• Copy of JCAHO current accreditation as a psychiatric hospital • Copy of Medical Director's current physician license • Enroll for Medicare crossovers only NOTE: This type and specialty is restricted to bill for Medicare Crossover Claims only. Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	
	90/004	Psychiatric/ Inpatient 65+	• Copy of JCAHO current accreditation as a psychiatric hospital • Copy of Medical Director's current physician license Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	
	90/005	Chronic - Inpatient	• Copy of Medical Director's current physician license Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	90/006	Alcohol & Drug Abuse Inpatient	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics Note: A copy of initial enrollment packet will be forwarded to the DSS Provider Enrollment Specialist for information after QA approval.	24 months	
	90/008	Psychiatric - Outpatient	• Copy of JCAHO current accreditation as a psychiatric hospital • Copy of Medical Director's current physician license	24 months	
	90/009	Alcohol & Drug Abuse Outpatient	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • List of satellite clinics Note: A copy of initial enrollment packet will be forwarded to the DSS Provider Enrollment Specialist for information after QA approval.	24 months	

	90/033	Psychiatric Residential Treatment Facility	• Copy of current attestation letter that includes the following information:
			  • Facility General Characteristics: name, address, telephone number of the facility, and a State provider identification number or "L" number (e.g., 07LXXX);
			  • Facility Specific Characteristics:
			  (a) bed size;
			  (b) number of individuals currently served within the PRTF who are provided service based on their eligibility for the Medicaid inpatient psychiatric services for individuals under age 21 benefit (Psych under 21)
			  (c) number of individuals, if any, whose Medicaid Psych under 21 benefit was paid
				60 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
			for by any State other than the State identified in the PRTF's attestation letter during the most recent state fiscal year; and (d) identify by list all States from which the PRTF has ever received Medicaid payment for the provision of Psych under 21 services. • A statement certifying that the facility currently meets all of the requirements of 42 CFR Part 441, Subpart D "Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs" and 42 CFR Part 483, Subpart G "Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21". • A statement acknowledging the right of the State Survey Agency (or its agents) and CMS to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences. • A statement that the facility will submit a new attestation of compliance annually and in the event a new facility director is appointed. • The signature of the facility director. • The date the attestation was signed. • Copy of current accreditation by JCAHO, CARF, Council on Accreditation of Services for Families and Children, or by any other accreditation organization, with comparable standards (subject to determination by the Department) • If an out-of-state provider: (a) current copy of home state Medicaid recognition as a PRTF or documentation that state of residence does not offer optional inpatient facility service for those under age 21; and (b) current copy of approval letter from DCF recognizing the facility as a PRTF servicing Connecticut children.		

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	90/111	Behavioral Health Clinic	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • For initial enrollment only, complete Mental Health and Substance Abuse Questionnaire (provided by DXC Technology as part of the provider's follow on document) Please note, in order to enroll in this type/specialty, you must be enrolled in Medicare and be in an active status. DSS will utilize the Center for Medicare and Medicaid Services' (CMS') PECOS system to validate this status prior to approving your enrollment/re-enrollment in the Connecticut Medical Assistance Program (CMAP).	24 months	
COMMUNITY FIRST CHOICE	50/501	CFC FI/PCA Services	• Copy of provider's contract with DSS in place of the Provider Agreement	60 months	
AUTISM WAIVER	51/503	Autism Waiver/Autism Service Provider	• Copy of letter from Beacon Health Options/DSS/DDS showing proof of successful credentialing as an Autism Care Plan Service Provider	24 months	
	51/504	Autism Waiver/Autism Fiscal Intermediary	• Copy of provider's contract with DSS in place of the Provider Agreement	24 months	
	51/505	Autism Waiver/Autism Case Management Provider	• N/A	N/A	
ACQUIRED BRAIN INJURY	52/026	ABI Case Management Provider	• Copy of case management contract with DSS, effective date/expiration date page only (Contract Summary Page) in place of the Provider Agreement	24 months	
	52/027	ABI Service Provider	• Copy of credentialing letter from Allied	24 months	
	52/029	Acquired Brain Injury Fiduciary	• Copy of provider's contract with DSS in place of the Provider Agreement	24 months	
BHH/ TCM/WAIVER BILLING PROVIDER	53/539	TCM – CMI Private Fee for Service	• Copy of credentialing letter issued by the Department of Mental Health and Addiction Services (DMHAS)	24 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
BHH/TCM/WAIVER PERFORMING PROVIDER	54/550	DMHAS Performing Provider – State Operated Facility	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document) • Copy of Joint Commission on Accreditation of Hospital Organizations (JCAHO) current accreditation as a psychiatric hospital • Mental Health and Substance Abuse Questionnaire (initial enrollment only)	36 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Type	Type/ Specialty	Description	Requirements	Enrollment Period	DPH License Type
	54/551	DMHAS Performing Provider – Private – Non-Profit	• Copy of Medical Director's current physician license • Statement from Medical Director accepting full professional responsibility for services (standard form provided by DXC Technology as part of the provider's follow on document); Please note, if provider does not provide medical services/have a medical director on staff, provider may submit a list of services provided, signed by the Chief Executive Officer (CEO), instead. • Mental Health and Substance Abuse Questionnaire (initial enrollment only)	36 months	
HOME/ COMMUNITY BASED PROVIDER	57/541	Access Agencies	• Copy of Access Agency contract with DSS, effective date/expiration date page only (Contract Summary Page)	60 months	
	57/543	CHC PCA Fiduciary	• Copy of provider's contract with DSS in place of the Provider Agreement	60 months	
	57/544	CHC Service Provider	• Letter from Allied Community Resources showing proof of successful credentialing as a CHC provider • Note: This requirement is waived **only** for the enrollment/reenrollment of Allied Community Resources as a 57/544 billing for environment adaptations and highly skilled chore.	24 months	
DDS SPECIALIZED SERVICES	59/509	Intellectual Disability	• Copy of credentialing letter issued by the Department of Developmental Services (DDS)	36 months	

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

Provider Enrollment/Re-enrollment/Add Alternate Service Location Address Application Criteria

APPENDIX A – License Type Definitions

1 - Physician In-State/Physician-Surgeon License/Resident Physician Permit 2 - Dentist/Provisional Faculty Dentist License/Resident Dental Permit 3 - Optometrist 5 - Naturopathic Physician 7 - Chiropractor 8 - Psychologist 9 - Homeopathic Physician 12 - Advanced Practice Registered Nurse 13 - Dental Hygienist 14 - Physical Therapist/PT Temporary Permit 16 - Licensed Nurse Midwife 17 - Audiologist 18 - Speech and Language Pathologist 19 - Podiatrist/Standard & Advanced Ankle Surgery Permit/Resident Podiatrist Permit 22 - Dental Anesthesia/Conscious Sedation Permit 23 - Physician Assistant/PA Temporary Permit 27 - Marital and Family Therapist 37 – Hearing Instrument Specialist 38 – Optician 43 - Acupuncturist 44 - Licensed Alcohol and Drug Counselor 45 - Certified Alcohol and Drug Counselor 46 - Professional Counselor 48 - Occupational Therapist/Occupational Therapist Temporary Permit 58 - Licensed Clinical Social Worker ALSA - Assisted Living Service Agency ASC - Ambulatory Surgical Center C – Certified EMS Organization CDH - Chronic Disease Hospital CCNH - Chronic & Convalescent Nursing Home CCRH - Chronic & Convalescent Nursing Homes and Rest Home with Nursing Supervision CH – Children's Hospital FP - Family Planning FR – First Responder GH – General Hospital HEMO -Hemodialysis HHC - Home Health Care	HSPC - Hospice INF – Infirmary L - Livery MAT - Maternity Hospital MHCR - Mental Health Community Resources MHRL - Mental Health Residential Living OPC - Outpatient Clinic POCA - Psychiatric Outpatient Clinic PSY - Hospitals for Mentally Ill Persons RHNS - Rest Homes with Nursing Supervision SA - Substance Abuse SR – Supplemental Responder