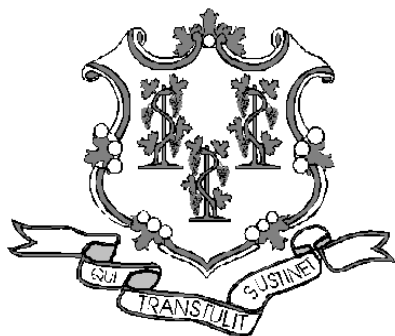




Web Re-enrollment Workshop for DDS Performing Providers



Presented by
The Department of Social Services
& Hewlett Packard Enterprise



Training Topics

➤ **Workshop Introduction**

➤ **www.ctdssmap.com Re-enrollment Wizard**

- ✓ Connecticut Medical Assistance Program (CMAP) Re-enrollment Process
- ✓ Re-enrollment Wizard Navigation
- ✓ Re-enrollment Wizard Walkthrough
- ✓ What's Next – Following the Process
- ✓ Notification of Re-enrollment Decision
- ✓ Re-enrollment Tracking
- ✓ Future Re-enrollment Notification

➤ **Resources**

➤ **Questions**

Introduction to the Re-enrollment Workshop

This workshop will provide guidance for the successful completion of an online Web Re-enrollment Application for providers of service participating in one of the following waiver programs under the Department of Development Services (DDS):

- Comprehensive Support Waiver
- Individual Family Support (IFS) Waiver
- MFP – IFS/Comprehensive Support Waiver
- FI MFP – IFS/Comprehensive Support Waiver

Re-enrollment Process

- Providers must be enrolled in the **Connecticut Medical Assistance Program (CMAP)** network in order to be reimbursed for services provided to clients.
- ACA mandates that providers must re-enroll periodically.
 - DDS Performing Providers – every 36 months
- Providers will re-enroll via the **Re-enrollment Wizard**, the Department of Social Services' online re-enrollment application tool.

Re-enrollment Process (cont.)

- Providers will be notified that it is time for re-enrollment via a letter.
 - Your letter will be mailed in October 2016.
 - Please note that, if you are a CCH provider, your letter will be mailed to the DDS Regional Office. The DDS Regional Office will then contact you to assist in the application process.
 - Your letter will contain an Application Tracking Number(s) (ATN) and AVRS ID.

Re-enrollment Process (cont.)

- An individual will only have one ATN/Medicaid ID. Below is a sample of the letter you will receive.

Smith, John
123 Summer St
Hartford, CT 06067

RE: Connecticut Medical Assistance Program

Provider Re-enrollment Application

AVRS ID: 001333445

Application Tracking Number (ATN): 200100

Re-enrollment Due Date: 04/15/2017

<u>Type Description</u>	<u>Specialty Description</u>	<u>Taxonomy Description</u>
BHH/TCM/Waiver Perform	Prov	DDS TCM Performer ----- Atypical

Dear Provider,

The Department of Social Services (DSS) Provider Participation Policy, set forth in section 17b-262-524 of the Regulations of Connecticut State Agencies, requires the periodic re-enrollment of all providers. Federal Medicaid regulations at 42 C.F.R. § 455.414 also require providers to reenroll periodically. The purpose of this letter is to notify you that you are now due for re-enrollment. Your re-enrollment application must be submitted and finalized by the re-enrollment due date provided above in order to avoid dis-enrollment from the Connecticut Medical Assistance Program. Please note that each application submitted must be processed by Hewlett Packard Enterprise and reviewed by the Department of Social Services' (DSS) Quality Assurance Unit. As a result, it is critical that you submit your application as soon as possible to allow adequate time for the process of the application prior to your re-enrollment due date.

If you do not submit your re-enrollment application in a timely manner, you will receive a notice warning you that your re-enrollment application will soon be automatically denied. **If you are currently an enrolled Connecticut Medical Assistance Program provider, your provider identifier will be de-activated on your re-enrollment due date and you will be dis-enrolled from the Connecticut Medical Assistance Program.**

To access your re-enrollment application, you must: _____

Re-enrollment Process (cont.)

- An organization may sometimes have multiple Medicaid IDs. The letter will identify each Medicaid ID that must be re-enrolled for an organization.

ABCD Corporation
123 Summer St
Hartford, CT 06067

RE: Connecticut Medical Assistance Program

Provider Re-enrollment Application

AVRS ID: 001234567
Primary Application Tracking Number (ATN): 211111

Re-enrollment Due Date: 04/15/2017

Dear Provider,

The Department of Social Services (DSS) Provider Participation Policy, set forth in section 17b-262-524 of the Regulations of Connecticut State Agencies, requires the periodic re-enrollment of all providers. Federal Medicaid regulations at 42 C.F.R. § 455.414 also require providers to reenroll periodically. The purpose of this letter is to notify you that your organization is now due for re-enrollment. Your re-enrollment must be submitted and finalized by the re-enrollment due date provided above in order to avoid dis-enrollment from the Connecticut Medical Assistance Program.

Re-enrollment Process (cont.)

- Sample letter (cont.)

Once your primary application has been submitted, re-enrollment applications must also be completed for the following AVRS IDs that are associated to your organization:

<u>ATN</u>	<u>AVRS ID</u>	<u>Provider Name</u>	<u>Re-enrollment Due Date</u>
211113	002113456	ABCD Corporation	04/15/2017
211114	001145668	ABCD Corporation	04/15/2017
211115	003333333	ABCD Corporation	04/15/2017
211116	009990000	ABCD Corporation	04/15/2017
211117	006111111	ABCD Corporation	04/15/2017

In order to streamline the re-enrollment process for each of these AVRS IDs, data updated when re-enrolling the primary ATN will be copied to each of the ATNs above. As a result, please do not begin the re-enrollment of these additional ATNs until the following business day after the primary ATN is completed. If you wish to proceed with any of the ATNs listed above on the same business day, you may do so. However, any data updated on the primary ATN will also need to be manually updated on any other applications processed on the same business day.

Re-enrollment Process (cont.)

- Organization Providers ONLY:
 - In order to streamline the re-enrollment process for each of your AVRS IDs, data updated when re-enrolling the primary ATN will be copied to each of the additional ATNs as noted in the previous slide.
 - **Please do not begin the re-enrollment of these additional ATNs until the following business day after the primary ATN is completed.**
 - If you wish to proceed with any of the ATNs as noted above on the same business day, you may do so. However, any data updated on the primary ATN will also need to be manually updated on any other applications processed on the same business day.

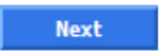



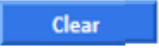


Re-enrollment Process (cont.)

- Once the letter is received, providers will access the Wizard's Re-enrollment Wizard from the Web Portal at www.ctdssmap.com.
 - Access to this application requires the ATN and AVRS ID included in the letter you will receive.
- Once you receive that letter, it is imperative that you complete your re-enrollment application as soon as possible.
- The re-enrollment process may take several weeks to complete.
 - Providers with re-enrollment applications not in an **“Approved” status by April 2017** will be dis-enrolled.

Re-enrollment Process (cont.)

- The online portion of this application process takes approximately 20 minutes to complete.
 - Applicants with **applications remaining idle for more than 20 minutes** will be booted from the re-enrollment wizard and required to restart the re-enrollment application process.
 - Applicants should gather all required data prior to beginning the application process.
 - **Partially completed applications cannot be saved** for future completion. Exiting the Wizard before completing the application will require you to restart your application.
 - **Completed applications may not be modified through the Web site**; required alterations must be mailed to the Provider Enrollment Unit.

Re-enrollment Wizard Navigation

- Use the *Process Bar* at the top of the screen to navigate between related panels
Instructions » Application Type » Employed by Group/Clinic/Hospital » Application For Provider Type/Specialty » Before You Continue » **National Provider Identifier Information**
- Click  to confirm the current panel data and move to the next panel
- Click  to go back to the previous panel
- Click  to leave the application – changes will NOT be saved
- Click  to add new entries to the relevant panel
- Click  to remove multiple entries at once
- Use *Radio Buttons*  to make selections between multiple choices
- Use *Check Boxes*  to indicate agreement or disagreement

Re-enrollment – Where to begin

- Go to the www.ctdssmap.com Home Page to access the Re-Enrollment Wizard and begin the application process.

The screenshot shows the homepage of the Connecticut Medical Assistance Program. The top navigation bar includes 'Home', 'Information', 'Provider', 'Trading Partner', 'Pharmacy', 'Information', and 'Hospital Modernization'. A left-hand menu is expanded to show 'Provider' options, with 'Provider Re-Enrollment' highlighted by a red arrow. A tooltip for 'Provider Re-Enrollment' is visible. The main content area features a large 'WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM' banner. Below the banner, there are four icons representing 'Information', 'Provider', 'Trading Partner', and 'Pharmacy'. At the bottom, there is an 'Important Messages' section with links for 'Provider Manual Update (Updated 4/5/16)' and 'CHC Agency Based Providers of Live-In Personal Care Assistance Services, Access Agencies, Fiscal Intermediary'.

Connecticut Department of Social Services
Making a Difference

Help
Sunday, April 10, 2016

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization

Information

- Publications
- Links
- Important Info
- RA Banner An
- HIPAA
- Regional Office

Provider

- Provider Serv
- Provider Sear
- Provider Enro
- EHR Incentive
- QOS Instructi
- Secure Site

Trading Partner

- Trading Partner Enrollment
- Trading Partner Documents
- Provider Electronic Solutions
- Billing Instructions

Pharmacy

- Pharmacy Information

Provider Enrollment

Provider Re-Enrollment

Provider Enrollment Tracking

Provider Matrix

Provider Services

Provider Search

Drug Search

Provider Fee Schedule Download

EHR Incentive Program

OOS Instructions/Information

ACA OPR Provider List

E-Mail Subscription

Secure Site

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HEWLETT PACKARD ENTERPRISE ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.

Information

Provider

Trading Partner

Pharmacy

Important Messages

[Provider Manual Update \(Updated 4/5/16\)](#)

[CHC Agency Based Providers of Live-In Personal Care Assistance Services, Access Agencies, Fiscal Intermediary](#)

Log into Your Re-enrollment Application

- Enter the ATN provided on your re-enrollment due notice, as well as your 9 digit AVRS ID. For organizations, you should begin with your “primary ATN”.

The screenshot shows the Connecticut Department of Social Services website. The header includes the logo and the text "Connecticut Department of Social Services Making a Difference". The date "Sunday, April 10, 2016" is displayed in the top right corner. A navigation menu contains links such as "Home", "Information", "Provider", "Trading Partner", "Pharmacy Information", and "Hospital Modernization". Below this, a secondary menu lists various services like "provider enrollment", "provider re-enrollment", "provider enrollment tracking", "provider matrix", "provider services", "provider search", "drug search", "provider fee schedule download", "ehr incentive program", "oos instructions/information", "aca ordering/prescribing/referring provider list", "e-mail subscription", and "secure site".

The main content area is titled "Log In to Your Re-Enrollment Application". It features a blue header with the same title and a help icon. Below the header, a bullet point instructs users to enter their Application Tracking Number (ATN) found on their re-enrollment notification letter or contact the Provider Assistance Center at 1-800-842-8440 for assistance. A note states "Required fields are indicated with an asterisk (*)".

There are two input fields: "ATN*" and "NPI/Non medical provider identifier (AVRS ID)*". Below the fields are two buttons: "Next" and "Exit".

Re-enrollment Instructions

- Once you enter the ATN and AVRS ID, additional panels will be displayed.
 - The panels will be pre-populated with data currently stored in the system.
 - Data on each panel must be reviewed and updated, if necessary. Required fields are indicated with an asterisk (*).
 - If required data is missing/omitted, or entered incorrectly, an error message will be displayed on the panel.

Re-enrollment Instructions

- The Provider Re-enrollment > Instructions panel provides an introduction to the online enrollment/reenrollment process.
- You are strongly encouraged to read through this page prior to beginning the re-enrollment process.
- Provides important information regarding application submission instructions.
- Once you have read the instructions, click **NEXT** to proceed.

Instructions

Welcome to the Connecticut Medical Assistance Program Provider Enrollment/Re-enrollment Wizard. This Wizard is available to providers newly enrolling in the program and those providers who are notified that it is time for re-enrollment into the program. This Wizard offers a simplified, expedited method of enrollment/re-enrollment.

Please note the following:

- Providers must enroll in the appropriate taxonomy/provider type/specialty to ensure accurate billing and reimbursement rates. A full list of taxonomies/provider types/provider specialties can be found at www.ctdssmap.com by clicking on Information, then Publications.
- The Wizard will not allow you to submit an incomplete application. If required fields are omitted, you will be prompted during the application process to correct those fields.
- If you have a popup blocker, you must add "www.ctdssmap.com" as Allowed Web Site.
- Once you have started an application, you cannot save an application in process and return to complete it later. Rather, you will be required to start a new application.
- Applicants may be presented with a Follow On Document which lists additional documentation that must be mailed to the Hewlett Packard Enterprise Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to Hewlett Packard Enterprise any of the required documents will result in a delay in processing your application.
- Once an application has been submitted, you cannot return to it to modify the application. Any changes to the application after it has been submitted must be mailed to:

Hewlett Packard Enterprise

Participation Type

- The next panel will differ if you are an individual versus an organization. In either case, a radio button will be auto-selected. No changes are required on this panel.

Individual

Participation Type

Required fields are indicated with an asterisk (*).

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

Individual practitioner

Employed/Contracted by an organization (to include residents)

Ordering/Prescribing/Referring provider only

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

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

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

[Previous](#) [Next](#) [Exit](#)

Organization

Organization Participation Type

Required fields are indicated with an asterisk (*).

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

Organization

Organization that is Employed/Contracted by Another Organization

DEFINITIONS:

Organization - An organization provider would be an entity who is considered the biller and performer of service. An example would be a hospital provider or an agency that bills on behalf of other providers. Reimbursement is made to the organization.

Organization that is Employed/Contracted by Another Organization - An organization that is associated to another entity that is responsible for billing the services provided. An example would be a group home for which services are billed through a State agency. Reimbursement is made to the billing entity.

[Previous](#) [Next](#) [Exit](#)

Re-enrollment – Provider Type/Specialty

- The following shows the next panel that is displayed. The type and specialty will be pre-populated as shown below. No changes are required to this data.



The screenshot shows a web form titled "Provider Type/Specialty". At the top, it states "Required fields are indicated with an asterisk (*)". There are two dropdown menus: "Provider Type" with the value "BHH/TCM/Waiver Performing Provider" and "Provider Specialty*" with the value "DDS TCM Performing Provider". At the bottom of the form, there are three buttons: "Previous", "Next", and "Exit".

- Select **Next**

Enrollment – Before You Continue

Before You Continue

Prior to continuing, it may be helpful to gather the following information which may be required on subsequent panels. Click on the links below to open a sample of a completed enrollment application.

- Full 9 digit zip codes for all addresses
- License Number
- Out of state providers must submit a copy of their license to Hewlett Packard Enterprise. This documentation must contain the Application Tracking Number (ATN) assigned at the end of this enrollment.
- Tax Identification (including SSN and date of birth for all stakeholders, including owners, partners)
- National Provider Identifier (NPI)
- Taxonomy Code
- Direct Deposit Bank information (for providers seeking direct reimbursement)
- CLIA Number(s) (if applicable)
- Medicare Number (if applicable)
- Physician Assistant's: Supervising Physician's Name, NPI, License
- Out of state provider wishing to enroll must first submit a claim to Hewlett Packard Enterprise
- The data you are required to enter may vary based on your provider type. The examples below demonstrate the maximum information that will be required from providers. A link to a sample application is provided below.

[Click here to open the Individual Practitioner Enrollment Application Sample](#)

[Click here to open the Employed by Organization Enrollment Application Sample](#)

[Click here to open the Organization Enrollment Application Sample](#)

[Click here to open the Organization Employed/Contracted by Org Enrollment Application Sample](#)

Click to view a sample application.

- Applicants may be presented with a Follow On Document which lists additional documentation that must be mailed to the Hewlett Packard Enterprise Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to Hewlett Packard Enterprise any of the required documents will result in a delay in processing your application.

Residents Only: Please note that many of the bulleted items above do not apply to residents. However, it may be helpful to gather the following before continuing: National Provider Identifier (NPI), sponsoring institution's address to include the full 9 digit zip code, and your Social Security Number.

Previous

Next

Exit

Re-enrollment – National Provider Identifier Information (NPI)

- Enter your NPI, if applicable and select your taxonomy from the drop down list. Click Next.

National Provider Identifier Information

■ **Important!** DSS has updated the provider type/specialty/taxonomy table. The taxonomy you are currently enrolled with may no longer be valid for your current provider specialty. If your current taxonomy is not offered as a selection, you may need to change your specialty by returning to the Provider Type/Specialty panel by clicking on the Provider Type/Specialty link at the top of this page

Required fields are indicated with an asterisk (*)

National Provider Identifier	1236954529
Primary Taxonomy*	261QM0850X - Ambulatory Health Care Facilities-Clinic-Adult Mental Health
Taxonomy 2	
Taxonomy 3	
Taxonomy 4	
Taxonomy 5	

Please Note: An NPI is not required. Providers who do not have an NPI should select the "atypical" taxonomy option.

Previous Next Exit

Valid Taxonomies

----- (atypical)
3747A0650X (Nursing Service Related-Attendant Care Provider)
373H00000X (Nursing Service Related-Day Training/Habilitation Specialist)

Re-enrollment – Name/Identifying Information

- The following panels will differ slightly between an individual and an organization. Apply updates if necessary and click Next to continue.
- **Re-enrollment:** Effective date = the date any changes to provider participation type, specialty, taxonomy or NPI should be effective. If no changes are made, the provider can enter today's date.

Individual

Individual Name

- The name entered on this line must match exactly the provider name submitted to the Internal Revenue Service and what is submitted on all other information supplied to the Connecticut Medical Assistance Program.

Required fields are indicated with an asterisk (*)

Last Name*

First Name*

Middle Initial

Date of Birth*

Gender* Female Male

Social Security Number* Do not enter dashes.

Identifying Information

- Indicate the date the provider wishes to become effective. This date cannot be further back than six months.
- Indicate the language(s) spoken by organization staff that is available to interpret for clients.

Required fields are indicated with an asterisk (*)

Provider Effective Date*

Languages English Spanish Portuguese Russian Polish Other

Organization

Identifying Information

- The name entered on this line must match exactly the provider name submitted to the Internal Revenue Service and what is submitted on all other information supplied to the Connecticut Medical Assistance Program.
- Indicate the language(s) spoken by organization staff that is available to interpret for clients.

Required fields are indicated with an asterisk (*)

Name - Organization*

Provider Effective Date*

If you are making changes to your provider record as part of this re-enrollment application (such as provider participation type, specialty, taxonomy or NPI), enter the date that these changes should be effective.

Languages English Spanish Portuguese Russian Polish Other

Re-enrollment – Service Location Address

- Review Service Location address and update, if necessary.
- Please Note: **P. O. Boxes are not allowed** in a service location address.
- After entering information into the Service Location **Address panel, information may be copied to other address panels by clicking the “Copy Svc Loc Addr” button within that panel.**

Addresses

Required fields are indicated with an asterisk (*).

Service Location Address

- Medicaid Contact Person and Telephone Number for Contact Person will be used for Medicaid administrative purposes only.
- Service location is the street address where a provider office is physically located and where the records are normally kept.

Service Location Address ?

Street Address Line 1* 487 MIDDLE ROAD

Street Address Line 2

City* FARMINGTON

State/ZIP* CT 06032 - 1211

Contact Person

Telephone Number - Contact Person* (860)738-1410 Ext.

Telephone Number - For Patient Use Ext.

Handicap Accessible? No

Contact Email

Confirm EMail

Fax

TDD/TTY

Re-enrollment – Mailing Address

- If the **Mailing Address** is the **same as the Service Location Address**, click the **“Copy svc Loc Addr”** to populate the information in the applicable panel(s), or update the address as necessary through this panel.

Mailing Address

■ Indicate the address where the Connecticut Medical Assistance Program should send general information and correspondence.

Mailing Address ? ↕

Street Address Line 1* 195 Scott Swamp Rd

Street Address Line 2

City* Farmington

State/ZIP* CT 06032 - 1234

Contact Person* Jessica Smith

Telephone Number - Contact Person* (860)555-1212 Ext.

Contact Email

Confirm EMail

Fax

Clear Copy Svc Loc Addr

- Click **Next**

Re-enrollment – Home Office Address

- If the **Home Office Address** is the **same as the Service Location Address**, click the **“Copy svc Loc Addr”** to populate the information in the applicable panel(s), or update the address as necessary through this panel.

The screenshot shows a web form titled "Home Office Address". The form contains several input fields: "Street Address Line 1*" with the value "487 MIDDLE ROAD", "Street Address Line 2" (empty), "City*" with the value "FARMINGTON", "State/ZIP*" with a dropdown menu showing "CT", "06032", and "1211". Below these are fields for "Contact Person", "Telephone Number - Contact Person*" with the value "(860)738-1410" and an "Ext." field, "Contact Email", "Confirm EMail", and "Fax". At the bottom right, there are two buttons: "Clear" and "Copy Svc Loc Addr". The "Copy Svc Loc Addr" button is highlighted with a red rectangular border.

- Click **Next**

Re-enrollment – Enrollment Address

- If the **Enrollment Address** is the **same as the Service Location Address**, click the **“Copy svc Loc Addr”** to populate the information in the applicable panel(s), or update the address as necessary through this panel.
- Enrollment address is the address to which all enrollment/re-enrollment correspondence will be mailed, including a provider’s notice to re-enroll. If a provider has a central credentialing unit or office member that performs that function, this is the information that should be reflected in the address and contact fields below.

The screenshot shows a web application interface for the 'Enrollment Address' section. At the top, there is a title bar 'Enrollment Address' with a help icon and a maximize icon. Below the title bar is a blue header bar with the text 'Enrollment Address'. A bulleted instruction reads: 'Enrollment address is the address to which all enrollment/re-enrollment correspondence will be mailed, including a provider's notice to re-enroll. If a provider has a central credentialing unit or office member that performs that function, this is the information that should be reflected in the address and contact fields below.' The form contains several input fields: 'Street Address Line 1*' (555 Ann ST), 'Street Address Line 2', 'City*' (Farmington), 'State/ZIP*' (DC 06032 - 1211), 'Contact Person*' (John Jones), 'Telephone Number - Contact Person*' ((860)555-1212 Ext. 555), 'Contact Email', 'Confirm EMail', and 'Fax'. At the bottom right of the form are two buttons: 'Clear' and 'Copy Svc Loc Addr'. Below the form is a navigation bar with 'Previous', 'Next', and 'Exit' buttons.

- Click **Next**

Re-enrollment – Alternate Service Location Addresses

- Enter any additional service location addresses applicable to the Waiver Services to be provided.
- To add an additional service location(s), fill in the appropriate information and click "Add."

Additional Service Location Address

Required fields are indicated with an asterisk (*).

Street Address Line 1	Street Address Line 2	City	State	Contact Person	Telephone Number - Contact Person
-----------------------	-----------------------	------	-------	----------------	-----------------------------------

Type changes below.

Street Address Line 1*

Street Address Line 2

City*

State/ZIP* -

Contact Person*

Telephone Number - Contact Person* Ext.

Handicap Accessible?

Contact Email

Confirm EMail

Fax

TDD/TTY

Enter additional service location information then click "add."

If no -applicable or all locations have been added, click next.

Re-enrollment – Tax ID Information

- This panel will be displayed for Organizations only. Review Taxpayer Identification Number (TIN) and TIN Effective Date and update, if necessary. Note: **Do not enter dashes.**
- Click **NEXT**.

The screenshot shows a web form titled "Tax ID Information" with a blue header. Below the header, a note states "Required fields are indicated with an asterisk (*)". The form contains two input fields: "Taxpayer Identification Number (TIN) Do not enter dashes*" with the value "XXX-XX-3593" and "TIN Effective Date*" with the value "06/19/2000". At the bottom of the form, there are three buttons: "Previous", "Next", and "Exit".

Re-enrollment – Member of Organization

- This panel will display the DDS billing provider to which you are associated. You will not be able to make any updates on this panel.
- Click **Next** to continue.

Member of Organization

Required fields are indicated with an asterisk (*).

Please select the following link to obtain a list of services provided under each of the DDS waiver programs: [Service to Waiver Cross Reference](#).

Organization ID	Organization Name	Organization Membership Effective Date
008021838		

Type changes below.

Member of Organization

Organization ID*

Organization Name

Organization Membership Effective Date*

Organizations

Organization Name	Type	Specialty	Address	City	State	Zip
Other						
MFP IFS COMP WAIVER BILLER	53 - BHH/TCM/Waiver Billing Provider	529 - MFP - IFS/Comp Waiver Biller	1922 NORTH MAIN ST ,	BRISTOL	CT	06010-

Re-enrollment - Attestation

- Review the **Electronic Signature** question.
- Answering **Yes** will open the Attestation.
- Read and signify whether or not your organization complies with the stated requirements. Click **Next** to continue.

Attestation

Required fields are indicated with an asterisk (*)

Electronic Signatures

Do you store your health records electronically? * Yes No

Previous Next Exit

Attestation

Required fields are indicated with an asterisk (*)

Electronic Signatures

Do you store your health records electronically? * Yes No

Electronic Signature Attestation:
Conditions for DSS Acceptance of Electronic Signatures

In order for DSS to accept electronic signatures on the Provider's medical records, the Provider shall, at a minimum, meet the requirements that are listed below. In addition, the Provider shall have written policies governing the assignment and use of electronic signatures on medical records that reflect these requirements. The requirements are as follows:

In order to authenticate and safeguard confidentiality of electronic signatures, the Provider shall assign each User of an electronic signature ("User") at least two (2) distinct identification components, such as an identification code and a password, which, together, shall constitute a "unique code." For the purposes of this Addendum, the User's name will not suffice as a password.

Before assigning the unique code, the Provider shall verify the identity of the User.

The unique code assigned by the Provider to a User shall not be assigned to anyone else.

The Provider shall certify, in writing, that the User is the only person authorized by the Provider to use the unique code that was assigned to him or her.

Each User shall certify, in writing, that, the User will not release his/her User identification code or password to anyone, or allow anyone to access or alter information under his/her identity.

Each Provider and each User shall certify, in writing, that the electronic signature is intended to be the legally binding equivalent of the User's traditional handwritten signature.

Yes. I certify that the Provider has policies that meet the Provider Enrollment Agreement Concerning the Acceptable Use of Electronic Signature requirements for acceptance of electronic signatures by DSS, and that the Provider meets all of the requirements for the issuance and use of electronic signatures.

No. I do not certify that I meet the requirements for acceptance of electronic signatures by DSS.

Previous Next Exit

Re-enrollment – Medicare Information

- If you are enrolled as a **participating provider with Medicare Part B**, select **Yes** on the panel below. This will display another panel where you can **provide your Medicare Number and the date that it became effective**.
- Click **NEXT** to proceed.

Medicare Information

Required fields are indicated with an asterisk (*)

Are you enrolled in Medicare? Yes No

Previous **Next** Exit

Medicare Information

Required fields are indicated with an asterisk (*)

Are you enrolled in Medicare? Yes No

Selecting "Yes" opens panel to enter Medicare Provider Number.

Enter data and click add. Enter each applicable number and effective date, clicking add after each entry.

Medical Information	
Medicare Number*	XXXXX4121
Effective Date*	01/01/2016

add

Previous Next Exit

Re-enrollment – Board Members, Partners or Managing Administrators Information

- This panel will be displayed for Organizations only.
- Enter responses to each of the questions.
- If yes to the last question, supply the **Name** and **Corporate Headquarters Location**. Click **NEXT**.

Board Members, Partners or Managing Administrators Information

Required fields are indicated with an asterisk (*)

Are you a nonprofit organization or an organization without an owner?* Yes No

Are there board members, partners, or managing administrators of your organization?* Yes No

For both nonprofit and profit organizations: If an organization has a board of directors (either paid or volunteer), the provider must supply the information for the administrative staff. The person(s) responsible for the day to day operations of the organization would include: President, VP, Treasurer, CEO, managing partners, etc.

Do all owners have less than 5% ownership in the organization? Yes No N/A

Is your corporation a subsidiary of another company?* Yes No

Name

Corporate Headquarters Location

[Previous](#) [Next](#) [Exit](#)

Re-enrollment – Board Members, Partners or Managing Administrators Information - Detail

- 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** to continue.

Board Members, Partners, or Managing Administrators Information-Detail

*** No rows found ***

Select row above to update -or- click Add button below.

Required fields are indicated with an asterisk (*)

Position*

Last name*

First Name, Middle Initial*

Street Address Line 1*

Street Address Line 2

City*

State/ZIP* -

SSN*

Date of Birth*

Add

Previous Next Exit

Re-enrollment-Controlling Interest

- This panel will be displayed for Organizations only.
- However, Controlling Interest information is **not required** for Non-Profit organizations or an organization without an owner. If not applicable, click **NEXT**.

Controlling Interest

Required fields are indicated with an asterisk (*).

- If you are a nonprofit organization or an organization without an owner, controlling interest information is not required.
- Indicate the person/persons who have a controlling interest in your organization.
- **Controlling Interest:** Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 5% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

Name	Percentage of Controlling Interest
BRANTLEY, PAUL	1

Type changes below

Re-enrollment – Controlling Interest (cont.)

- Organizations are required to indicate the person or persons who have controlling interest in the organization.

The screenshot shows a web form for adding a controlling interest entry. The form is enclosed in a light blue border and contains the following fields:

- Last Name* (text input)
- First Name* (text input)
- Middle Initial (text input)
- Relationship* (dropdown menu)
- Medicaid Provider Number (if applicable) (text input)
- Social Security Number* (text input)
- Date of Birth* (text input)
- Street Address Line 1* (text input)
- Street Address Line 2 (text input)
- City* (text input)
- State/ZIP* (dropdown menu, text input, and text input)
- Telephone Number - Business (text input) and Ext. (text input)
- Percentage of Controlling Interest* (text input)

At the bottom right of the form, there are two buttons: "add" and "cancel". The "add" button is highlighted with a red rectangular box.

If more than one controlling interest entry is applicable, click add after completing the panel and add the next entry. Click add to save last entry.

Re-enrollment – Controlling Interest (cont.)

- After entering data for all parties with controlling interest, complete the remaining questions.
- Answering **Yes** to controlling interest in any other provider will open the “Controlling Others” window.

The percentage of ownership does not equal 100%. The remaining owners have less than 5% ownership in the organization. Yes No

Does the applicant and/or owner, partner, member or officer have an ownership or controlling interest in any other provider? * Yes No

*** No rows found ***
- Enter data below and click on add button -

Controlling Others ? ↕

Name*

Street Address Line 1*

Street Address Line 2

City*

State/ZIP* -

Complete panel and click add to save. Click add after completing each additional controlling interest.

Click Next to continue.

Re-enrollment - Survey

- Answer **Yes** or **No** to each question in the survey. Answering **yes** to any question will **require** you to submit **additional information**.
- Click **add** after entering the required supplemental data. **The survey questions that you are required to answer vary for State Operated versus Private Non-Profit providers.**

Survey

Required fields are indicated with an asterisk (*)

1. Is, or was, applicant a Medicaid provider in any other state? *

Yes No

*** No rows found *** - Enter data below and click on add button -

Survey

State* National Provider Identifier Number* Date*

2. Is applicant a provider for any other federal program, e.g., MEDICARE? *

Yes No

3. Has the applicant ever been denied enrollment in Medicaid, Medicare or any other state or federal program? *

Yes No

4. Does applicant contract with any private health insurance providers? *

Yes No

*** No rows found *** - Enter data below and click on add button -

Survey

Insurance Name* Contract Number*

5. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family or marriage? *

Yes No

6. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family, marriage, ownership, membership, control, or business relationship to any other provider that is currently, or within the last 5 years, has been, enrolled in the Connecticut Medical Assistance Program? *

Yes No

Re-enrollment - Summary

- Click to **open the Provider Enrollment Agreement**.
- **After Reading** the Agreement, **click the “I agree to reading and terms” box**.
- Make **all changes** to the application **before clicking submit**.

Summary

[Click here to open Provider Enrollment Agreement](#)

I agree that I have read and accept the terms of the Provider Enrollment Agreement

SSN of Person Signing the Application" XXXXX5121

Signature of Provider or Authorized Representative" Chris Johnson

Enter SSN and signature of Provider/Authorized Representative

Click to acknowledge reading and agreeing to terms

- The Application has been completed and is ready to submit. If any changes need to be made, please make them now by using this Web site's navigation links and command buttons (not the browsers navigation buttons).
- **IMPORTANT NOTICE:** In receiving this application from and granting Medicaid enrollment to the individual or other entity named as "Provider Applicant," the Connecticut Medical Assistance Program relies on the truth of all the following statements:

I certify that, if I am granted status as a provider for Connecticut Medical Assistance programs, I expressly agree to the following: to abide by all applicable federal and state statutes, regulations, policy transmittals, and provider bulletins; to keep accurate and current records regarding the nature, scope and extent of services furnished to Medical Assistance recipients; and to furnish information pertaining to any claim for Medicaid payment, whether made by me or on my behalf, to the Connecticut Department of Social Services, the Secretary of Health and Human Services, and the offices of the Connecticut Chief State's Attorney and the Connecticut Attorney General, or their agents, upon request. I will make such information available for inspection and/or copying, and/or will provide copies of such information, upon request.

I certify that I have legal authority to enter into contracts and agreements on behalf of the provider.

- After you submit the application, you will be able to print and/or save the application as a PDF.
- Select "Submit" to submit the application.

Previous Submit Exit

Re-enrollment – Application Submitted

- Please take note of the Application Tracking Number (ATN). You **must put the ATN on all required follow-on documents or modifications** sent to Hewlett Packard Enterprise once your application has been submitted.
- Click on the **“Save a copy of the application”** link to print or save the PDF version of your application for your records.

Application Submitted

- Thank you for applying for enrollment with the Connecticut Medical Assistance Program. The information on your submitted application will now be reviewed by Hewlett Packard Enterprise. If any information is missing, invalid, or Hewlett Packard Enterprise is unable to process the application, you will receive written notification of the missing or invalid information from Hewlett Packard Enterprise. Providers will not be able to correct or modify completed applications using the Wizard but will need to submit paper corrections to the following address:

Hewlett Packard Enterprise
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104
- Application Tracking Number (ATN)
 - Your tracking number is 310831
- Notification of Enrollment Decision

If all information has been provided and is correct, Hewlett Packard Enterprise will submit a completed application to the Department of Social Services Quality Assurance Unit for review.

 - If an **approval** is received from the Department of Social Services, the Hewlett Packard Enterprise Provider Enrollment Unit completes the enrollment process in the interChange system and sends a Provider Enrollment Approval Notice to the provider. New providers are encouraged to view the Medical Assistance Program Provider Manual on the www.ctdssmap.com Web site located by clicking on Information then Publications from the Home Page.
 - **Important:** In order to avoid future claim denials, newly approved provider groups, clinics, hospital outpatient clinics and FQHC providers must also ensure that each performing provider is enrolled in the Connecticut Medical Assistance Program as an individual member of the organization. If the member is not already enrolled, they must utilize this online Web portal enrollment Wizard to do so. If the member is already enrolled but simply needs to be associated to the organization, the organization, once approved, may do this on the Secure Web portal via Demographic Maintenance.
 - If a **denial** is received from the Department of Social Services, Hewlett Packard Enterprise sends a Provider Enrollment/Re-enrollment Rejection Notice to the provider. This letter outlines the reason(s) the application was denied. A provider receiving a denial from 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 submit an application via this Enrollment Wizard.
- **Save a copy of the application** for your records only. *

Do not send this application to the Connecticut Medical Assistance Program.

* If you are having problems opening PDF file. Please [click here](#) to download the file directly.

Exit



WHAT'S NEXT - FOLLOWING THE PROCESS

DDS RE-ENROLLMENT ON THE WEB

Re-enrollment – What's Next

Organizations Only

- If you are an Organization with multiple Medicaid IDs to enroll, you must follow the steps above to complete a re-enrollment application for each Medicaid ID.
- However, you are strongly encouraged to wait until the next business day prior to completing the remainder of your applications.
- This will allow time for data entered on your primary ATN to be copied to your remaining ATNs and will lessen the amount of data re-entry you will need to do.

Re-enrollment – What's Next

Individuals and Organizations

- The information on your submitted **application will now be reviewed by Hewlett Packard Enterprise.**
- If any information is missing, invalid, or if Hewlett Packard Enterprise is unable to process the application, you will receive a letter that informs you what is required for correction or completion of your application.
- Providers will not be able to correct or modify completed applications online, but will need to submit paper corrections to the following address:
 - Hewlett Packard Enterprise
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104
- **All additional information sent to Hewlett Packard Enterprise will need the ATN entered on the upper right hand corner.**

Notification of Re-enrollment Decision - Approval

- **If all information has been provided and is correct,** Hewlett Packard Enterprise will submit the completed application to the Department of Social Services (DSS) Quality Assurance Unit for review.
- **If an approval is received from the DSS,** the Provider Enrollment Unit completes the re-enrollment process and sends a **Provider Re-enrollment Approval Notice to the provider.**

Notification of Enrollment Decision - Denial

- If a denial is received from the Department of Social Services (DSS), Hewlett Packard Enterprise sends a Provider Enrollment/Re-enrollment Rejection Notice to the provider. This letter outlines the reason(s) the application was denied.
- A provider receiving a denial from DSS' Quality Assurance Unit must follow the instructions for responding to the denial as outlined in the Rejection Notice.
 - DSS will notify Hewlett Packard Enterprise if their decision of denial has been reversed.
 - Hewlett Packard Enterprise will make the appropriate updates and an approval letter will be sent to the provider.
- In order to reapply to the Connecticut Medical Assistance Program, a provider must once again submit an application via the online Enrollment Wizard.

Checking the Status of Your Application Online

- From the www.ctdssmap.com Web site click Provider > Provider Enrollment Tracking.
- Enter the ATN and your business name as enrolled.

The screenshot displays the Connecticut Department of Social Services website. The top navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, and Hospital Modernization. The left sidebar menu is expanded to the 'Provider' section, where 'Provider Enrollment Tracking' is highlighted with a red box. The main content area features a large 'WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM' banner. Below the banner is the department's logo and a secondary navigation bar with 'Provider Enrollment Tracking' highlighted in red. The 'Enrollment Tracking Search' section contains two input fields: 'ATN*' and 'Business OR Last Name*'. A red box highlights the 'Enrollment Tracking Search' header.



FUTURE RE-ENROLLMENT NOTIFICATION

DDS RE-ENROLLMENT ON THE WEB

Re-enrollment – Notification and Process

- Providers will receive a reminder letter when they are due for re-enrollment **6 months prior** to the end of their previous 3 year contract.
 - The reminder letter will include a new Application Tracking Number.
 - To re-enroll providers should:
 - Access the www.ctdssmap.com Web site
 - From the Home Page click Provider > Provider Re-enrollment
 - Enter the ATN received in the re-enrollment reminder letter
 - Enter AVRS ID and follow steps outlined above

Re-enrollment – Notification and Process cont.

- Providers should successfully **complete the re-enrollment application as quickly as possible** upon receipt of their notice.
- Providers with **re-enrollment applications** that are **not fully completed by** the provider's re-enrollment **due date** will receive a notice advising they have been **dis-enrolled** from the Connecticut Medical Assistance Program (CMAP).
- A Provider Enrollment contract will not be reinstated until the **application is finalized.**
 - Reinstatement of contracts w/out a finalized application violates ACA policies.

Provider Enrollment/Re-enrollment Resources

- **Where to go for help:**

- www.ctdssmap.com – From the Home page navigate to Information > Publications > Provider Manuals
- Chapter 3 – Provider Enrollment and Re-enrollment
- Chapter 10 - Web Portal/AVRS

- <https://nppes.cms.hhs.gov> – National Plan & Provider Enumeration System – for providers interested in obtaining more information about obtaining a National Provider Indicator (NPI).

Provider Enrollment/Re-enrollment Resources

- **Provider Assistance Center:**

Monday through Friday, 8:00 a.m. – 5:00 p.m. (EST),
excluding holidays

1-800-842-8440 (toll free)

- **Provider Enrollment Unit:**

Hewlett Packard Enterprise
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104

Re-enrollment – Questions & Answers

- Questions & Answers

