ATN_____

CONNECTICUT MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT/RE-ENROLLMENT APPLICATION

Please type or neatly print the requested information. Do not leave any areas blank. Enter N/A if not applicable to you. Incomplete data may delay approval of this application. Contact the HP Provider Assistance Center local to Farmington at 860-269-2028 or toll-free in state at 800-842-8440 if you have questions about this application form.

Section A. Please check as applicable.

☐ New Provider
☐ Re-enrollment
☐ Individual Practitioner
☐ Group Practice

If Group Practice:
Name of Group Practice_____
- and -
NPI/Non-medical Provider Identifier(s)_____

Section B. 1. Provider Name_____

2. Provider Type_____ 3. Provider Specialty_____

4. NPI/Non-medical Provider Identifier _____

4a. Previous NPI/Non-medical Provider Identifier(s)_____

5. Medicare Provider Number(s) _____

6. Primary Taxonomy_____

6a. Taxonomy (list up to four additional) i._____ _____ ii. _____
iii. _____iv. _____

7. Federal Tax ID Number_____ Effective Date_____

8. State Tax ID Number _____

9. License/Certification Number_____ Effective Date _____

10. Clinical Laboratory Improvement Act (CLIA) Number(s)_____

11a. Language(s)_____

11b. ADA Accommodations_____

12**. Primary Service Location Address**

Address_____

Address_____

City_____ State_____Zip_____

Contact Name _____ ___Phone ( ) Fax ( )

E-mail Address _____ ___Handicap Accessible Y N TTY/TDD ( )

13. **Provider Home Office Address**

Address_____

Address_____

City_____ State_____Zip_____

Contact Name _____ ___Phone ( ) Fax ( )

E-mail Address _____ ___Handicap Accessible Y N TTY/TDD ( )

14. **Provider Pay To Address**

Address_____

Address_____

City_____ State_____Zip_____

Contact Name _____ ___Phone ( ) Fax ( )

E-mail Address _____ ___Handicap Accessible Y N TTY/TDD ( )

15. **Provider Mail To Address**

Address_____

Address_____

City_____ State_____Zip_____

Contact Name _____ ___Phone ( ) Fax ( )

E-mail Address _____ ___Handicap Accessible Y N TTY/TDD ( )

16 a-b**. Alternate Service Location Addresses *(Please use the Additional Enrollment/Re-enrollment Data Form if there are additional alternate service locations.)***

LOCATION A

Address_____

Address_____

City_____State_____ Zip_____

Contact Name _____Phone( )

Fax ( )

Email Address_____

Handicap Accessible Y N TTY/TDD( )

LOCATION B

Address_____

Address_____

City_____State____Zip_____

Contact Name Phone( )

Fax ( )

Email Address_____

Handicap Accessible Y N TTY/TDD( )

17 a,b,c**. *Please check as applicable:***

Fill in as applicable: (*attach separate listing if necessary****)***

☐ 17a. I am a contractor for an enrolled Medical Assistance Provider. Name of Provider_____

☐ 17b. I am an employee of an enrolled Medical Assistance Provider. Name of Provider_____

☐ 17c. If re-enrolling, there has been a substantial change in ownership of my organization. Date of change_____

Describe type of change_____ _____

18. I have signed the addendum for electronic signatures on medical records. Y N

19. Provider Signature _____ Date _____

PRINT NAME_____

TITLE_____

20. NPI/Non-Medical Provider Identifier_____ **21. Effective Date** _____

HP USE ONLY