

Resident Enrollment Step by Step Instruction Guide

Overview

The following presents a step by step guide on completing an application for enrollment as a resident in the Connecticut Medical Assistance Program. Completion of this application is a very easy and quick process. Prior to beginning the application, please ensure that you have the following information readily available:

- Your National Provider Identifier (NPI) as issued by the National Provider Plan and Enumeration System (NPES). The taxonomy you registered with on NPES must be the student taxonomy.
- Your Social Security Number (SSN)
- Your Sponsoring Organization's Address or Program's Address, to include a full nine digit zip code, as well as your residency advisor's name, phone number and email address

You will not be able to submit your application without the above information.

Re-enrollments:

The following steps will also apply when a resident must submit a re-enrollment application. The resident will receive a re-enrollment due letter six (6) months prior to the resident's re-enrollment due date. This letter will contain the re-enrollment application tracking number (ATN) and provider ID needed to initiate the Web re-enrollment application. If your residency ends prior to the re-enrollment date included on the letter, you do not need to re-enroll. You may disregard this letter.

If your residency period is continuing after the re-enrollment due date indicated on the letter, it is imperative you successfully complete the re-enrollment application as quickly as possible upon receipt of the letter. Residents with re-enrollment applications that are not fully completed by the residents' re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP).

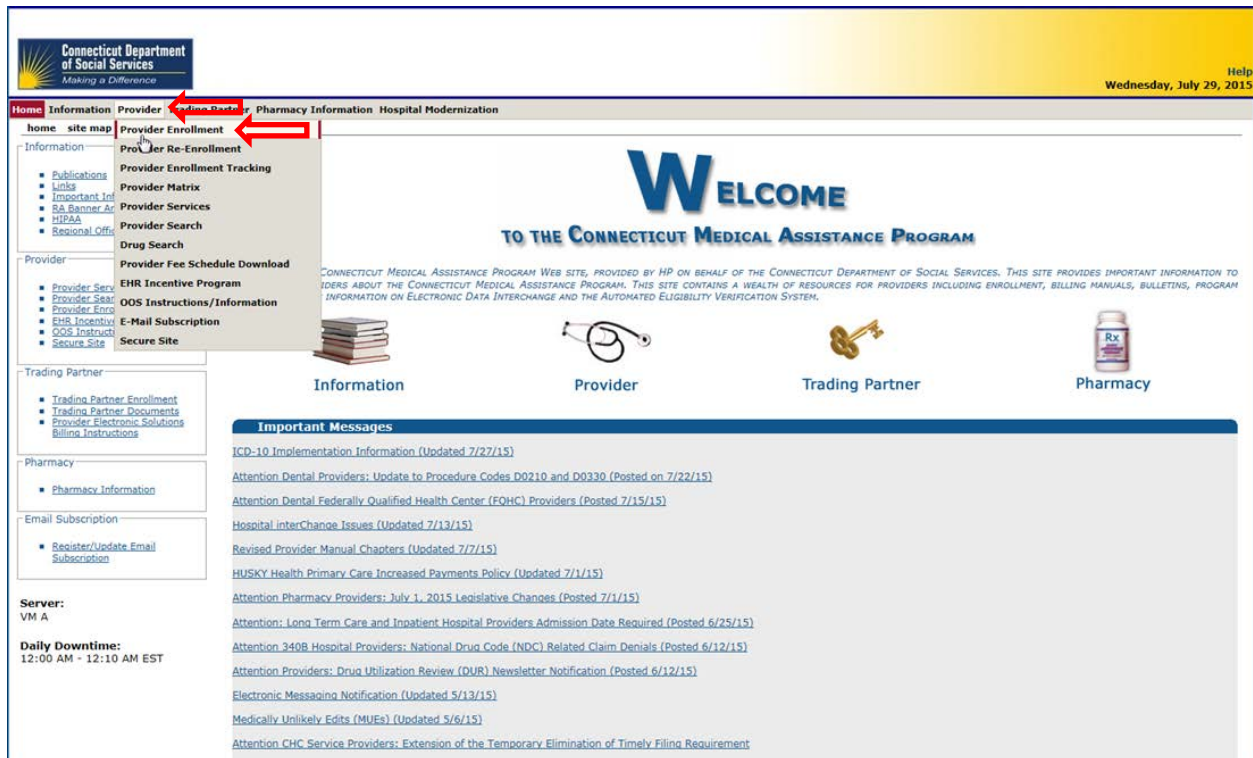
Please note that the vast majority of the information in the re-enrollment application will be auto-populated based on the information that is currently in the database. It is imperative that the resident, or his/her representative, review every panel to ensure that the information there is the most current.

Instructions

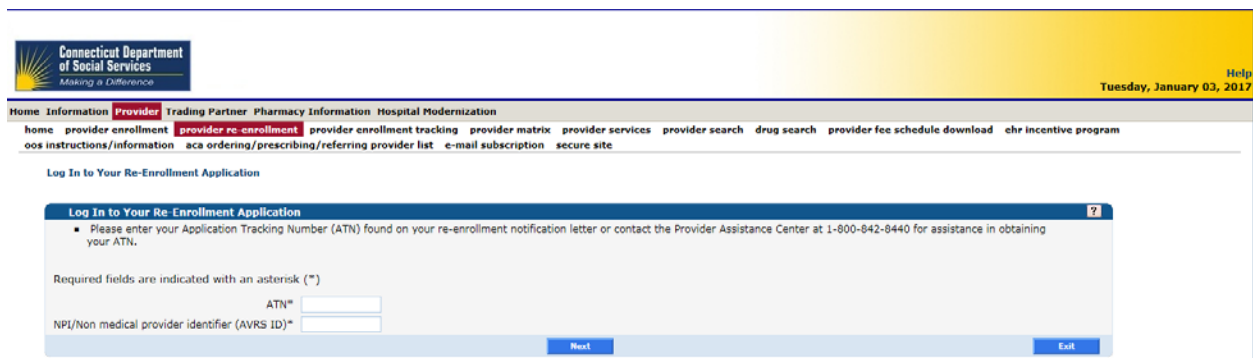
1. Access the Web site for the Connecticut Medical Assistance Program at www.ctdssmap.com. Please note that the Web portal Enrollment Wizard is unavailable at certain times during the day due to regular/scheduled system downtime. To access the system availability schedule on the www.ctdssmap.com Web site, click on Provider, then Provider Services, and scroll down to the POS/AEVS System Availability link under the Schedules section of the Provider Services

page. In the unlikely event of any unplanned downtime, an Important Message is posted to the Home page of the www.ctdssmap.com Web site.


2. Once on the Web site, select Provider.
 - a. If you are newly enrolling, select Provider Enrollment, as shown below.



- b. If you are re-enrolling, select Provider Re-enrollment, as shown below. Once this panel is displayed, enter the ATN listed on your re-enrollment due letter as well as your NPI or AVRS ID and select Next.



3. Review the instructions on the Instructions Panel and select Next.



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Instructions

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 HP Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to HP 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:

HP
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104

Exceptions to Web Enrollments:

The Wizard is available to all provider groups and provider taxonomy/type/specialties, with the exception of the following:

- Private Non-Medical Institution Billing and Performing Providers
- Regional Family Service Coordination Center (RFSCC) (Birth to Three) Billing and Performing Providers
- Personal Care Services
- Acquired Brain Injury Fiduciary
- ABI II Waiver Billing Providers
- DMHAS TCM/DDS Billing and Performing Providers
- Employment and Day Support Waiver Billing and Performing Providers
- Connecticut Home Care (CHC) Personal Care Assistant (PCA) Fiduciary
- Mental Health Waiver Performing Providers
- Autism Waiver Performing Providers
- Early Childhood Autism Waiver Billing and Performing Providers

Note to Out-of-State Providers:

Out-of-State providers that provide services to children who are enrolled in programs equivalent to a Department of Children & Family or a department such as a Department of Developmental Services, currently seeking enrollment in the Connecticut Medical Assistance Program, may do so using the Enrollment/Re-enrollment Wizard.

All other out-of-state providers may use the Enrollment/Re-enrollment Wizard if they have received approval from the Department of Social Services. Out-of-state providers may obtain approval by first submitting the claims for which they seek reimbursement to HP at the following address:

HP
Written Correspondence
OOS Claims
P. O. Box 2991
Hartford, CT 06104

Please click the "next" button to start the enrollment application.

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4. On the Application Type panel, select Individual and click Next as shown below. **NOTE:** for re-enrollments, the radio button will be pre-populated and not changes are required.

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Instructions » Application Type

Application Type

Required fields are indicated with an asterisk (*)

Type of Application *

☒ Individual

☐ Organization/Group

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5. On the Participation Type panel, select Employed/Contracted by an Organization (to include **residents**) and click Next as shown below. **NOTE:** for re-enrollments, the radio button will be pre-populated and not changes are required.

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Instructions » Application Type » Participation Type

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/re-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.

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6. For a newly enrolling provider, Initial Enrollment should already be selected on the Application For panel. Select Next as shown below to continue your application. For a re-enrolling provider, Re-enrollment should already be selected. Select Next to continue.

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Instructions » Application Type » Participation Type » Application For

Application For

Required fields are indicated with an asterisk (*)

This Application is for *

☒ Initial Enrollment

☐ Re-enrollment

* Initial Enrollment should be selected when the applicant has never participated in the Connecticut Medical Assistance Program. Initial Enrollment should not be selected if the applicant is now or was ever actively enrolled. Initial Enrollment is not a means to join another organization such as a group, clinic, or outpatient hospital. If an Initial Enrollment application is received from a provider who is currently on file, regardless of their current participation status, the application will not be processed. The provider will be instructed to re-enroll in the program by contacting the Provider Assistance Center at 1-800-842-8440 for assistance in obtaining an Application Tracking Number (ATN) needed for re-enrollment.

* If you have been notified that it is time for re-enrollment, please select Re-enrollment. You will need your Application Tracking Number (ATN) and NPI or Non-medical provider identifier (AVRS ID) in order to re-enroll. Your ATN is found on your re-enrollment letter or you can contact the Provider Assistance Center at 1-800-842-8440 for assistance in obtaining your ATN. If you have previously been enrolled in the Connecticut Medical Assistance Program and are attempting to re-join, you must first contact the Provider Assistance Center to obtain an ATN so that you may re-enroll.

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7. On the Provider Type/Specialty panel, use the drop down arrow on the Provider Type field to display the list of provider types. From that list, select Resident. For a re-enrolling resident, this information will be auto-populated.

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Provider Type/Specialty

Provider Type/Specialty

Required fields are indicated with an asterisk (*)

Provider Type*

Advance Practice Nurse
Autism Specialist
Behavioral Health Clinician
Chiropractor
CT Home Care Program
Dentist
Naturopath
Nurse Midwife
Optician
Optometrist
Physician
Physician Assistant
Podiatrist
Resident
TCM/ODS/DMHAS Performing Provider
Therapist

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8. Click on any space in the Provider Type/Specialty panel again (or select Next) to display the Provider Specialty field as shown below. Use the drop down arrow on the Provider Specialty field to display the list of provider specialties. From that list, select either Medical Resident, Dental Resident or Podiatry Resident and then select Next. For a re-enrolling resident, this information will be auto-populated.

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Provider Type/Specialty

Provider Type/Specialty

Required fields are indicated with an asterisk (*)

Provider Type* Resident

Provider Specialty*
Dental Resident
Medical Resident
Podiatry Resident

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9. The Before You Continue panel is then displayed. Please review the section indicated below for Residents, ensure you have all necessary information, and select Next to continue with your application.

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Provider Type/Specialty » **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 HP. 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 HP
- 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

- Applicants may be presented with a Follow On Document which lists additional documentation that must be mailed to the HP Provider Enrollment Unit in order for your enrollment/re-enrollment application to be considered complete. Failure to mail to HP 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.

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10. On the National Provider Identifier Information panel, enter your NPI in the National Provider Identifier field. Please note that the Primary Taxonomy field defaults to the Student Taxonomy. No additional updates are required to this field or any of the other Taxonomy fields. Click Next after entering your NPI to continue your application. For a re-enrolling resident, this information will be auto-populated.

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Provider Type/Specialty » Before You Continue » **National Provider Identifier Information**

National Provider Identifier Information

Required fields are indicated with an asterisk (*)

National Provider Identifier: 1122334455

Primary Taxonomy* 390200000X - Student in an Organized Health Care Education/Training Program

Taxonomy 2

Taxonomy 3

Taxonomy 4

Taxonomy 5

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11. On the Identifying Information panel, enter the following fields as shown below and select Next:

- Last Name
- First Name
- Middle Initial (optional)
- Date of Birth
- Gender
- Social Security Number (SSN)

Please note that (after entry) the date of birth and SSN fields appear masked with “X”s to protect Personally Identifiable Information (PII).

Please note that the Name and SSN entered on this panel must match exactly to the Name and SSN submitted on the Summary panel at the end of this enrollment Wizard.

For a re-enrolling resident, this information will be auto-populated.

The screenshot shows the 'Individual Name' section of the Connecticut Department of Social Services enrollment wizard. The header includes the department logo and the date 'Wednesday, July 29, 2015'. The navigation bar lists various services, with 'Provider' and 'provider enrollment' highlighted. The breadcrumb trail indicates the current step: 'Instructions > Application Type > Participation Type > Application For Provider Type/Specialty > Before You Continue > National Provider Identifier Information > Individual Name'. The form itself has a title bar 'Individual Name' and a note: '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.' Below this, a note states 'Required fields are indicated with an asterisk (*)'. The form fields are: 'Last Name*' (containing 'Application'), 'First Name*' (containing 'Resident'), 'Middle Initial' (empty), 'Date of Birth*' (masked as 'XX/XX/1980'), 'Gender*' (with 'Female' selected and 'Male' as an option), and 'Social Security Number*' (masked as 'XXX-XX-3333'). A note 'Do not enter dashes.' is placed between the SSN field and the navigation buttons. At the bottom of the form are three buttons: 'Previous', 'Next', and 'Exit'. A red arrow points to the 'Next' button.

12. On the Identifying Information panel, whether the provider is initially enrolling or re-enrolling, enter the following fields and then select Next.

- Provider Effective Date (Please note that this cannot be any earlier than June 1 of the current residency year.)
- Resident End Date (Please note that this should reflect the length of your residency. For visiting residents, this should indicate the date your rotation in CT is scheduled to end.)
- Sponsoring Organization (Please note this should reflect the Organization that is sponsoring your residency.)
- College Graduated From (Please note this field will only be displayed for Podiatry residents, and should reflect the college from which you graduated.)
- Languages (optional)

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Identifying Information

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* 07/01/2015

Please specify your scheduled residency end date in the following field. For visiting residents, the following field should indicate the date your rotation in CT is scheduled to end.

Resident End Date 06/30/2017

Please specify the organization which is currently sponsoring your residency Hartford Hospital

Please specify the college from which you graduated UConn

Languages

- ☒ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Russian
- ☐ Polish
- ☐ Other

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13. On the Addresses panel, enter your sponsoring organization's or program's address. Enter your residency advisor as the contact name, with their associated telephone number and email address. Once those fields have been completed, select Next as shown below.

- Street Address Line 1
- Street Address Line 2 (Please note that this address line may include specific information to ensure any letters mailed reach the appropriate staff/department at your sponsoring organization/program.)
- City
- State/Zip Code with +4 Zip Code Extension
- Contact Person
- Telephone Number – Contact Person
- Telephone Number – Patient Use (A telephone number for patient use is helpful when a client needs to contact a provider. This allows the provider to store both their business and patient use telephone numbers.)
- Handicap Accessible (optional)
- Contact Email
- Fax (optional)
- TDD/TTY (optional)

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Identifying Information » **Addresses**

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.
- Residents are required to provide the address of their sponsoring institution. Please note that street address line 2 may include specific information to ensure any letters mailed reach the appropriate staff/department at the resident's sponsoring organization.

Street Address Line 1*

Street Address Line 2

City*

State/ZIP* -

Contact Person*

Telephone Number - Contact Person* Ext.

Telephone Number - For Patient Use* Ext.

Handicap Accessible? ☒ No ☐ Yes

Contact Email

Fax

TDD/TTY

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14. On the Attestation panel, respond to the question about whether health records are stored electronically. Yes must be selected if any of this sites at which you currently perform services store their health records electronically. If Yes is selected, additional text as shown below under “Electronic Signature Attestation:” is presented for review. Respond accordingly to the statements at the bottom of the panel and then select Next as shown below.

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Identifying Information » Addresses » **Attestation**

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.

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15. On the Survey panel, respond Yes or No to each of the four questions and select Next as shown below. Please note that a response to each question is required at both initial enrollment and re-enrollment. If you select Yes to any of the questions, another text box may be displayed prompting you for more detailed information, as shown after the first question below.

The screenshot shows the 'Survey' panel of the Connecticut Department of Social Services Provider Enrollment system. The header includes the department logo and the date 'Wednesday, July 29, 2015'. A navigation bar contains links such as 'Home', 'Information', 'Provider', 'Trading Partner', 'Pharmacy Information', 'Hospital Modernization', 'home', 'provider enrollment', 'provider re-enrollment', 'provider enrollment tracking', 'provider matrix', 'provider services', 'provider search', 'drug search', 'provider fee schedule download', and 'ehr incentive program'. Below this is a breadcrumb trail: 'Instructions » Application Type » Participation Type » Application For Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Individual Name Identifying Information » Addresses » Attestation » Survey'. The survey itself consists of four questions, each with 'Yes' and 'No' radio buttons. Question 1 is 'Is, or was, applicant a Medicaid provider in any other state? *'. Below it is a table with the message '*** No rows found ***' and a red prompt '- Enter data below and click on add button -'. The table has columns for 'State*', 'National Provider Identifier Number*', and 'Date*', with an 'add' button. Question 2 is 'Is applicant a provider for any other federal program, e.g., MEDICARE? *'. Question 3 is 'Has the applicant ever been denied enrollment in Medicaid, Medicare or any other state or federal program? *'. Question 4 is 'Has there been any disciplinary, administrative, civil, or criminal actions taken against applicant, a family member, partner, member, director, officer or managing employee in any way related to the provision of health care goods or services, including but not limited to those goods or services covered by Medicare or Medicaid? *'. At the bottom of the survey panel are 'Previous', 'Next', and 'Exit' buttons. A red arrow points to the 'Next' button. The footer contains links for 'Home', 'CT.gov Home', 'Site Map', 'About Us', and 'Feedback'.

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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 -

State*	<input type="text"/>	National Provider Identifier Number*	<input type="text"/>	Date*	<input type="text"/>	<input type="button" value="add"/>
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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. Has there been any disciplinary, administrative, civil, or criminal actions taken against applicant, a family member, partner, member, director, officer or managing employee in any way related to the provision of health care goods or services, including but not limited to those goods or services covered by Medicare or Medicaid? *

☐ Yes ☒ No

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16. On the Summary panel, you must select “Click here to open Provider Enrollment Agreement” and fully review the document that is displayed both at initial enrollment and re-enrollment. Once reviewed, you are required to acknowledge that you have read and accept the terms of that agreement. You must again supply your SSN and a signature, review the additional language on the panel, and select Submit as shown below.

Please note that the Name and SSN entered on this panel must match exactly to the Name and SSN submitted on the Individual Name panel completed earlier in this enrollment Wizard application.

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Summary

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* XXX-XX-3333

Signature of Provider or Authorized Representative* Resident App.

- 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.

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17. Once your application has been submitted, you will see an Application Tracking Number (ATN) on the Application Submitted panel, shown below. From this panel, you have the option to save a hard copy of the information saved via the Web application. You may now select Exit.

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Wednesday, July 29, 2015

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Summary » **Application Submitted**

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 HP. If any information is missing, invalid, or HP is unable to process the application, you will receive written notification of the missing or invalid information from HP. 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:

HP
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06104
- Application Tracking Number (ATN)
 - Your tracking number is 309886
- Notification of Enrollment Decision

If all information has been provided and is correct, HP 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 HP 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, HP 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

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Please do not send a hard copy of this application to Hewlett Packard Enterprise once you have submitted it via the Web. Once your application has been submitted, no additional action is needed by the resident or the hospital for enrollment in the Connecticut Medical Assistance Program. Hospitals **are not required** to associate residents under the hospital's AVRS ID.

Once submitted, the application will be reviewed by DSS' Quality Assurance Unit and you will be notified via a letter of your approval or denial for participation in CMAP. The reasons for denial are minimal, but may include the following:

- Resident not registered on NPPES as a student. You must supply a valid NPI that exists on NPPES with a student taxonomy.

- Resident found to not be in compliance with any federal regulations (For example, DSS' Quality Assurance Unit will validate any provider that appears on the Office of Inspector General's sanction list. Any providers found to be on this list are denied enrollment in CMAP.)

Please note that, while not a reason for an application to be denied, in order for a resident to participate in CMAP, they must be issued a permit through the Department of Public Health. Your sponsoring organization/program, the hospital, is responsible for submitting to DPH their list of residents. If you attempt to enroll/re-enroll in CMAP and are not present on the DPH permit file, your enrollment/re-enrollment application will be suspended until such time that you have been issued a permit. Your sponsoring organization/program should obtain instructions for submission of the resident file on DPH's Web site at <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=543188>.

Tracking the Status of an Application

You may track the status of your application at www.ctdssmap.com by selecting Provider > Provider Enrollment Tracking.

The screenshot shows the Connecticut Medical Assistance Program (CMAP) website. The navigation menu on the left includes links for Information, Provider, Trading Partner, Pharmacy, and Email Subscription. The main content area features a large 'WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM' banner. Below the banner, there is a section titled 'Important Messages' with several updates and notices, including 'CD-10 Implementation Information (Updated 7/27/15)', 'Attention Dental Providers: Update to Procedure Codes D0210 and D0330 (Posted on 7/22/15)', and 'Attention Pharmacy Providers: July 1, 2015 Legislative Changes (Posted 7/1/15)'. A red arrow points to the 'Provider Enrollment Tracking' link in the navigation menu.

On the Provider Enrollment Tracking panel, enter your ATN and name to obtain a status of your application. Possible statuses include:

- HPE Reviewing Submitted Application – Your application has been received by HP and is currently being reviewed to determine what required information is missing.

- **Awaiting DPH Permit Info** – Your application is in a pending status and will be reviewed by Hewlett Packard Enterprise. If your sponsoring organization/program has submitted a permit application for you to the Department of Public Health, no additional action is required from you or your sponsoring organization/program, unless otherwise notified by Hewlett Packard Enterprise. Hewlett Packard Enterprise will review your permit information and forward your application to DSS for review. If that has not yet been submitted, please request that your sponsoring organization/program submit a permit application to DPH, using the instructions found on DPH's Web site at <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=543188>. DPH will then forward the permit information to Hewlett Packard Enterprise. Once the permit information is received from DPH, your application will automatically be sent to DSS for review. No additional action is required from you or your sponsoring organization/program at that time.
- **DSS Init Rvw/OIG or Survey Flag** – Your application has passed the Hewlett Packard Enterprise review process and is currently with DSS' Quality Assurance Unit for review of OIG and/or Survey Responses. (The OIG file is a file that the Office of the Inspector General maintains and lists providers that should be excluded from participating in the Medicaid program. This list is accessed at the time of initial and re-enrollment into the CMAP program. Providers, once enrolled, are also validated against this list on a monthly basis. If a provider is found on this list, DSS may elect to terminate the provider's participation in the CMAP program; or, deny the application.)
- **DSS Review of Resident Application** – Your application has passed the Hewlett Packard Enterprise review process and is currently with DSS' Quality Assurance Unit for review.
- **Waiting Application or Information from Provider** – A request has been sent requesting additional information necessary to finalize your application.
- **DSS Approved** – Your application has been approved by DSS. You will soon be receiving a letter indicating that approval.
- **Denied/Letter Needed** – Your application has been denied by DSS. You will soon receive a letter indicating the reason for denial.
- **HPE Denied** – Hewlett Packard Enterprise has denied your application for reasons such as: The sponsoring organization/program is located outside of Connecticut.
- **DSS Denied** – DSS has denied your application and a denial letter has been mailed.
- **Enrollment Completed** – You have successfully enrolled in CMAP.
- **Re-enrollment Completed** – You have successfully re-enrolled in CMAP.

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Help
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Enrollment Tracking Search

ATN*

Business OR Last Name*

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Please note that it may take up to 14 days for your application to be finalized.

Annual Resident Validation and Provider Re-enrollment

Once enrolled, an annual validation will be done to ensure you continue to be present on the DPH permit file. No action is required by the resident to complete this validation process. Residents with a residency period greater than three years will be required to re-enroll every three years via the on-line Re-enrollment Web Wizard. A notification will be sent as you approach your re-enrollment due date with instructions on how to re-enroll.

Obtaining Full Licensure

If you are a currently enrolled resident and become fully licensed through the Department of Public Health prior to the time you are due to re-enroll, you must enroll in CMAP as a fully-licensed provider. To enroll, please select Provider Enrollment via the www.ctdssmap.com Web site. At this time, you will select the appropriate provider type (such as "Physician" or "Dentist") and the appropriate specialty. You will then be asked to supply all relevant provider information, including your DPH license number. Upon enrollment under your newly licensed specialty, you will receive a new AVRS ID.

For Hospitals: List of Ordering/Prescribing/Referring Providers

To verify if the resident is going through enrollment or is already enrolled, hospitals can view the list of ordering/prescribing/referring providers on the Home page of the provider's secure Web site at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links.