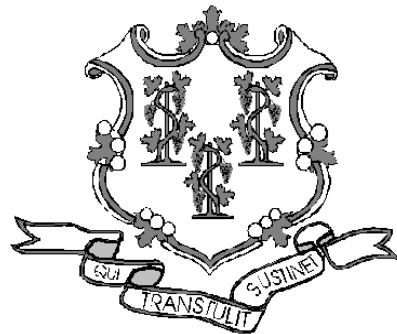




Web Enrollment/Re-Enrollment Workshop for School Based Child Health (SBCH) Providers



Presented by
The Department of Social Services
& Hewlett Packard Enterprise



Training Topics

- **Workshop Introduction**
- www.ctdssmap.com **Enrollment or 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 Enrollment Workshop

This workshop will provide guidance for the successful completion of an online Web Enrollment/Re-Enrollment Application for School Based Child Health (SBCH) providers of SBCH services.

Enrollment/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.
- The Affordable Care Act (ACA) mandates that providers must re-enroll periodically.
 - SBCH Providers – every 36 months
- Providers will enroll/re-enroll via the **Enrollment/Re-Enrollment Wizard**, the Department of Social Services' online enrollment/re-enrollment application tool.

Re-Enrollment Process (cont.)

- Providers will be notified that it is time for re-enrollment via a letter received from Hewlett Packard Enterprise, **six months prior** to the provider's **re-enrollment due date**.
 - The letter will contain an Application Tracking Number(s) (ATN) and AVRS ID.
 - The letter will also contain the provider's re-enrollment due date.
 - A provider's re-enrollment application must be **approved** and in a **finalized status** by their re-enrollment due date.

Re-enrollment Process (cont.)

This is a sample re-enrollment letter. Note the AVRS ID, Application Tracking Number and Re-Enrollment Due Date.

ABCD Corporation
123 Summer St
Hartford, CT 06067

RE: Connecticut Medical Assistance Program

Provider Re-enrollment Application

AVRS ID: **001234567**

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.)

- 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 their re-enrollment due date** 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.
 - **Once submitted 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 **Next** to confirm the current panel data and move to the next panel
- Click **Previous** to go back to the previous panel
- Click **Exit** to leave the application – changes will NOT be saved
- Click **Add** to add new entries to the relevant panel
- Click **Clear** 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.

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 Offic

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

QOS Instructions/Information

ACA OPR Provider List

E-Mail Subscription

Secure Site

Information

Provider

Trading Partner

Pharmacy

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 THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS SOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA HE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.

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 login page for the Connecticut Department of Social Services Provider Re-enrollment application. The page has a yellow header bar with the text "Help" and "Sunday, April 10, 2016". The main content area includes a logo for the Connecticut Department of Social Services, a navigation bar with links like "Home", "Information", "Provider", "Trading Partner", "Pharmacy", "Hospital", and "Modernization", and a sub-navigation bar with links for "home", "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". Below the navigation is a link to "Log In to Your Re-Enrollment Application". The main form area has a title "Log In to Your Re-Enrollment Application" and a note: "Please enter your Application Tracking Number (ATN) found on your re-enrollment notification letter or contact the Provider Assistance Center at 1-800-842-8440 for assistance in obtaining your ATN." It includes fields for "ATN*" and "NPI/Non medical provider identifier (AVRS ID)*", and buttons for "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 re-enrollment 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

Re-Enrollment Application Type

School Based Child Health Providers should confirm that **Organization/Group** has been pre-selected for their Application Type. Click **NEXT**.

Instructions » Application Type

Application Type

Required fields are indicated with an asterisk (*)

Type of Application *

Individual
 Organization/Group

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

Re-Enrollment Organization Participation Type

- School Based Child Health Providers should confirm that **Organization** has been pre-selected for their Participation Type. Click **NEXT**.

Instructions » Application Type » **Organization Participation Type**

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

1. Confirm **Special Services** is pre-populated as the **Provider Type**.
2. Click **Next** to populate the **Provider Specialty** field.
3. Confirm **School Corporation** is pre-populated for the **Provider Specialty**.
4. Click **NEXT**.

Instructions » Application Type » Organization Participation Type » Application For Provider Type/Specialty

Provider Type/Specialty

Required fields are indicated with an asterisk (*)

Provider Type*

Provider Specialty*

Re-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](#)

- 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)

- Confirm **NPI**.
- The taxonomy is pre-populated in the Primary Taxonomy field.
- Click **NEXT**.

Instructions » Application Type » Organization Participation Type » Application For Provider Type/Specialty » Before You Continue » **National Provider Identifier Information**

National Provider Identifier Information

Required fields are indicated with an asterisk (*)

National Provider Identifier

Primary Taxonomy*

Taxonomy 2

Taxonomy 3

Taxonomy 4

Taxonomy 5

Re-enrollment – Name/Identifying Information

- Confirm data pre-populated on this panel. Add data or make changes as needed.

Instructions » Application Type » Organization Participation Type » Application For Provider Type/Specialty » Before You Continue » National Provider Identifier Information » **Identifying Information**

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 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 (*)

Name - Organization*

Provider Effective Date*

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.
■ 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.

Service Location Address	
Street Address Line 1*	487 Middle RD
Street Address Line 2	
City*	Farmington
State/ZIP*	CT <input type="button" value="▼"/> 06032 - 1211
Contact Person*	John Smith
Telephone Number - Contact Person*	(860)555-1212
Telephone Number - For Patient Use*	(860)555-1212
Handicap Accessible?	No <input type="button" value="▼"/>
Contact Email	
Confirm Email	
Fax	
TDD/TTY	

Re-enrollment – Mailing Address

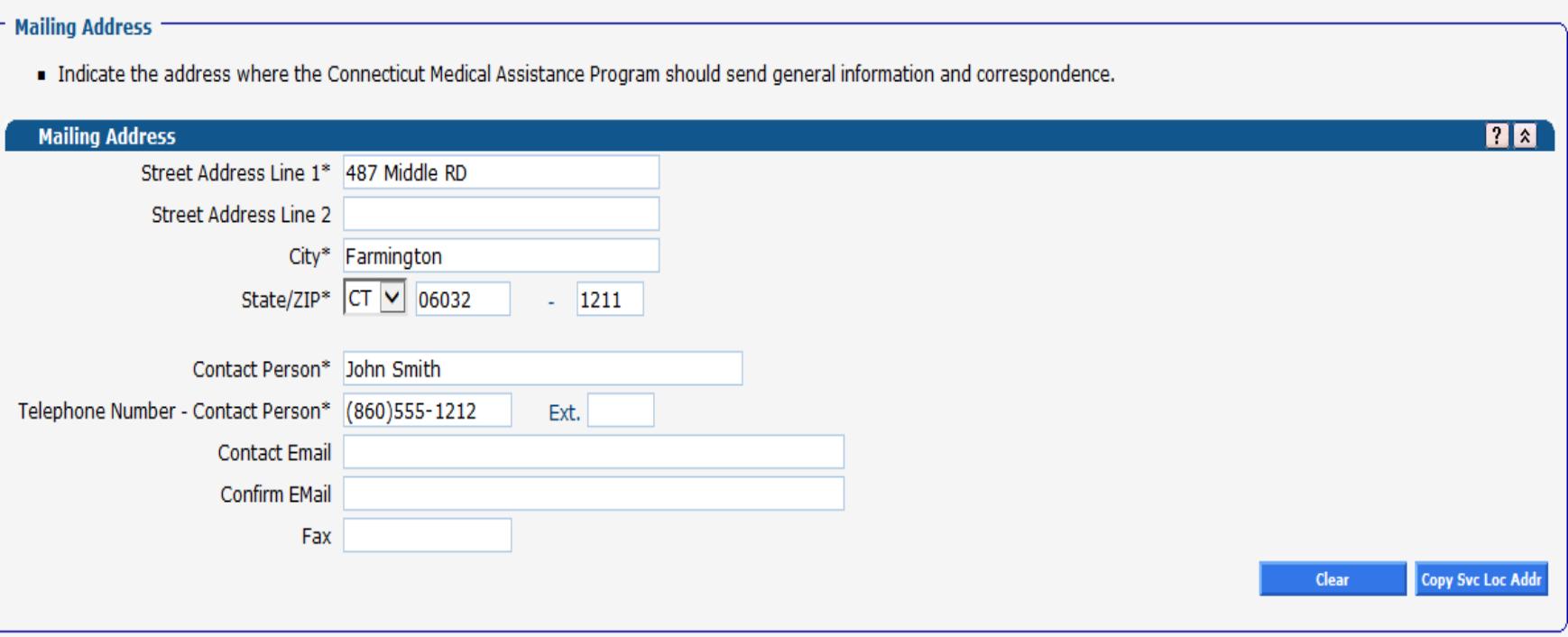
- If the **Mailing Address** is the **same as the Service Location Address**, click the “**Copy svc Loc Addr**” to populate the information in the applicable panel(s), or update the address as necessary through this panel.

Mailing Address

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

Street Address Line 1*	487 Middle RD	?	^	
Street Address Line 2				
City*	Farmington			
State/ZIP*	CT	06032	-	1211
Contact Person*	John Smith			
Telephone Number - Contact Person*	(860)555-1212	Ext.		
Contact Email				
Confirm EMail				
Fax				

Clear **Copy Svc Loc Addr**



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.

Home Office Address

▪ Indicate the provider's Home Office address.

Home Office Address

Street Address Line 1*	487 Middle RD	?	^
Street Address Line 2			
City*	Farmington		
State/ZIP*	CT	06032	- 1211
Contact Person*	John Smith		
Telephone Number - Contact Person*	(860)555-1212	Ext.	
Contact Email			
Confirm Email			
Fax			

Clear **Copy Svc Loc Addr**

Check and Remittance Advice Address

- If the **Check and Remittance Advice 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.

Check and Remittance Advice Address

Indicate the address where checks and remittance advice information should be sent. Most providers are required to receive this information electronically.

Street Address Line 1*	487 Middle RD	?	^	
Street Address Line 2				
City*	Farmington			
State/ZIP*	CT	06032	-	1211
Name - Financial Contact Person*	John Smith			
Telephone Number - Contact Person*	(860)555-1212	Ext.		
Contact Email				
Confirm EMail				
<input type="button" value="Clear"/> <input type="button" value="Copy Svc Loc Addr"/>				

1099 Mailing Address

- If the **1099 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.

1099 Mailing Address

- This is the address where the IRS Form 1099 will be sent.

1099 Mailing Address

Street Address Line 1*	487 Middle RD	?	^
Street Address Line 2			
City*	Farmington		
State/ZIP*	CT	06032	- 1211
Telephone Number	(860)555-1212	Ext.	
		Clear	Copy Svc Loc Addr

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.

Enrollment Address

- 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.

Enrollment Address	?	^
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		
Fax		
Clear Copy Svc Loc Addr		

- Click **Next**

Re-Enrollment Financial Information

- This information must be the current taxpayer information on file with the IRS.
- Do not enter dashes.
- Click **NEXT.**

Instructions » Application Type » Organization Participation Type » Application For Provider Type/Specialty » Before You Continue » National Provider Identifier Information » Identifying Information Addresses » **Financial Information**

Financial Information

▪ The Connecticut Medical Assistance Program will generate payments to you and report income to the Internal Revenue Service (IRS) using this information. This information must be the current taxpayer information on file with the IRS. Please note: The "Name" and the "Doing Business As" fields are NOT address fields. Please enter only your name in the "Name" field. If you are conducting business and are reporting income to the IRS under a different name, please enter that name in the "Doing Business As" field.

Required fields are indicated with an asterisk (*)

Taxpayer Identification Number (TIN)* Do not enter dashes.

Name*

Doing Business As

TIN Type* EIN SSN

State Tax ID

I attest that I do not collect sales tax or do not have employees.

Previous **Next** **Exit**

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

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 – Board Members, Partners or Managing Administrators Information

- 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

- Typically, a school district is a municipal entity governed by a local or regional board of education and is not organized as a corporation. Thus, in most cases, a school district is required only to disclose, in this section of the application, its managing employees. In rare cases, especially if a school district is governed by a board or owner(s) other than a local or regional board of education, the additional questions in this section may apply. Please contact the SBCH Program at DSS.SBCH@ct.gov if you have any questions.

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

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 ***

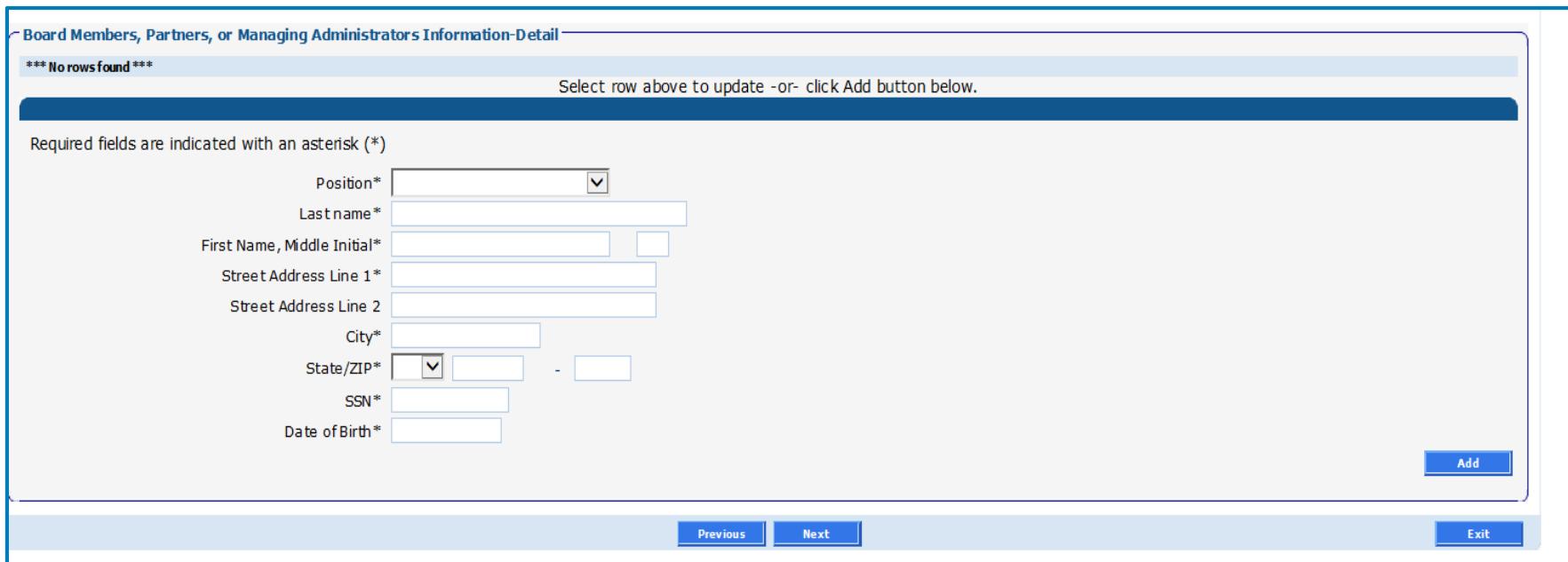
Select row above to update -or- click Add button below.

Required fields are indicated with an asterisk (*)

Position*	<input type="text"/>
Last name*	<input type="text"/>
First Name, Middle Initial*	<input type="text"/>
Street Address Line 1*	<input type="text"/>
Street Address Line 2	<input type="text"/>
City*	<input type="text"/>
State/ZIP*	<input type="text"/> - <input type="text"/>
SSN*	<input type="text"/>
Date of Birth*	<input type="text"/>

Add

Previous | Next | Exit



Re-enrollment-Controlling Interest

- Controlling Interest information is **not required** for Non-Profit organizations or an organization without an owner. However, if applicable, click **NEXT**.

Controlling Interest

Required fields are indicated with an asterisk (*).

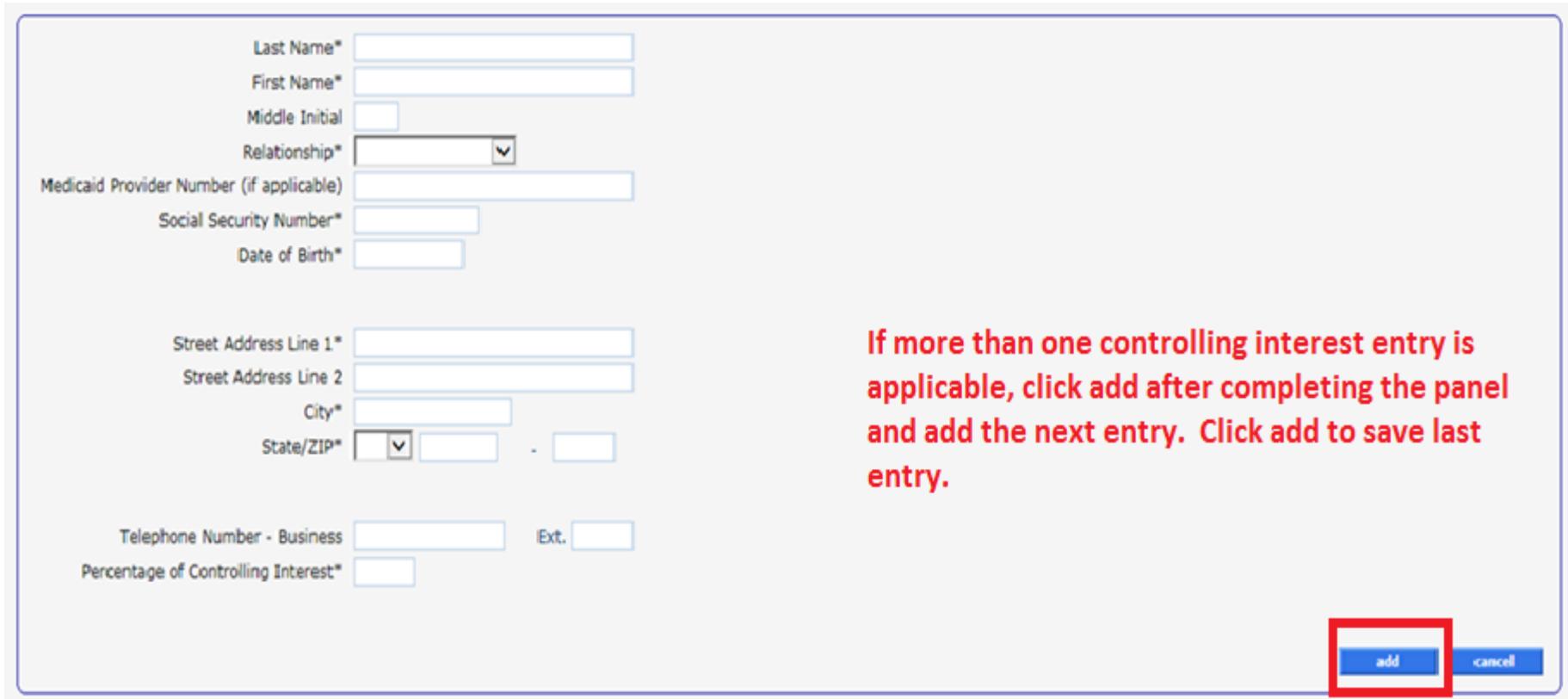
- If you are a nonprofit organization or an organization without an owner, controlling interest information is not required.
- Indicate the person/persons who have a controlling interest in your organization.
- **Controlling Interest:** Controlling interest includes, but is not limited to, those enumerated; 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.



Form fields:

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

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.

Buttons: **add** (highlighted with a red box) | cancel

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*	<input type="text"/>
Street Address Line 1*	<input type="text"/>
Street Address Line 2	<input type="text"/>
City*	<input type="text"/>
State/ZIP*	<input type="text"/> - <input type="text"/>

add

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

Click Next to continue.

Previous **Next** Exit

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.

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*	add
--------	--------	--------------------------------------	-------	-----

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*	add
--------	-----------------	------------------	-----

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

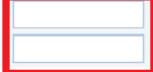
Re-enrollment - Summary

- Click to **open the Provider Enrollment Agreement**.
- **After Reading** the Agreement, **click the “I agree to reading and terms” box**.
- **Authorized Representative/SSN must be listed in the Partners/Members section of the application.**

Summary

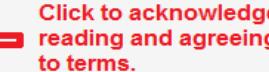
[Click here to open Provider Enrollment Agreement](#)

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

SSN of Person Signing the Application* 

Signature of Provider or Authorized Representative* 

Enter SSN and signature of Authorized Representative
Note: The individual signing must be listed in the Partners/Members section of the application. 

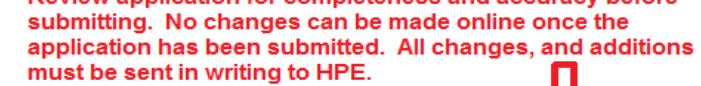
Click to acknowledge reading and agreeing to terms. 

▪ 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.

Review application for completeness and accuracy before submitting. No changes can be made online once the application has been submitted. All changes, and additions must be sent in writing to HPE. 

Submit  **Exit**

[Previous](#)

Re-enrollment – Application Submitted

- Please take note of the Application Tracking Number (ATN). You **must put the ATN on all re-enrollment correspondence** 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

SBCH RE-ENROLLMENT ON THE WEB

Re-enrollment – What's Next

- 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 submitted 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 Re-Enrollment Decision - Denial

- If a denial is received from (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.

Connecticut Department of Social Services
 Making a Difference

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization

Information

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Trading Partner

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Important

WELCOME

TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

FUTURE RE-ENROLLMENT NOTIFICATION SBCH 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 approved and finalized** 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

