



Dear Provider:

The Department of Social Services (DSS) thanks you for your interest in participating in the Connecticut Medical Assistance Program. Every effort has been made to streamline the enrollment/re-enrollment process. We encourage providers to enroll or re-enroll on the Internet using the following site – www.ctdssmap.com. Detailed instructions for Internet enrollment and re-enrollment are provided once you access the Internet application. Re-enrollments are accessed via the secure provider portal and must be completed by the provider's Web ID administrator once they are logged into the Web site. Clerk IDs cannot perform a Web re-enrollment. Please remember that completing a Web based enrollment/re-enrollment also requires some of the documents outlined below to be mailed into the HP Provider Enrollment Unit.

Note: Nursing Facilities (Long Term Care) and State Institution (ICF/MR) providers must enroll using a paper application and cannot use the Internet enrollment/re-enrollment function.

The following steps are required for those providers that choose to enroll/re-enroll using the attached paper packet. The following steps must be followed to ensure accurate processing of your enrollment/re-enrollment application. Review the contents of the enclosed packet carefully. Please complete all required sections and supply all requested information. The completed packet should be mailed to:

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

Incomplete applications cannot be processed and will be returned. Please contact the Provider Assistance Center at (800) 842-8440 or local to Farmington at (860) 269-2028 if you have questions about this application.

For re-enrolling providers:

- Failure to re-enroll will result in deactivation of your NPI/Non-medical provider identifier in the Connecticut Medical Assistance Program.
- Providers who have had no claim activity within the last 12 months will be automatically dis-enrolled. If this occurs, the provider must complete a new provider application in order to be considered for enrollment in the Connecticut Medical Assistance Program.

In the packet are the items described below:

1. Enrollment/Re-enrollment Form

This page is titled “Connecticut Medical Assistance Program Enrollment/Re-enrollment Application”. Instructions for this application are titled “Instructions for the Enrollment/Re-enrollment Form”.

Pages two through six must also be completed and returned. Instructions for these pages are titled “Instructions for pages 2 through 5” and “Instructions for page 6”.

2. Additional Enrollment/Re-enrollment Data Form

If you must supply additional information for a specific field on the first page of the Enrollment/Re-enrollment Form, enter the information on this form.

3. Connecticut Department of Social Services Provider Enrollment Agreement

This form must be read by the provider, signed, and returned with the enrollment form. ALL signatures must be original. For Nursing Facility and State Institution – ICF/MR providers, the Department of Public Health will provide you with a Department of Social Services’ Nursing Facility or ICF/MR Enrollment Agreement for you to complete. This agreement, along with your Certification and Transmittal Form, will be submitted to HPs’ Provider Enrollment unit on your behalf.

Please Note: Provider Groups & FQHC Clinics

Re-enrolling groups and FQHC Clinics must provide the following:

- A copy of this agreement should be made available for each existing group member to sign or in the case of FQHCs, all performing members need to sign the agreement.
- A master agreement for the entire group must be completed and signed by the group’s or FQHC’s chief executive officer.
- A list of group or FQHC performing members that are being re-enrolled in the group or FQHC Clinic is required. The list must contain the individual’s name, the individual’s NPI/non-medical provider identifier, and the individual’s license number. For dental groups and FQHC clinics, this list must also include the taxonomy of each group member. Only those group members for whom all enrollment information is received, including the provider agreement, will be re-enrolled.
- If a new member is to be added to your group or FQHC Clinic at re-enrollment that is not currently enrolled in the Connecticut Medical Assistance Program, a copy of this packet must be completed by that group or FQHC performing member.

4. Notice to Providers

This document outlines the penalties for violations connected with the Connecticut Medical Assistance Program.

5. W-9 Form

All providers must complete this form with the taxpayer identification number and the business name associated with that number. Check the appropriate box to indicate whether the provider is an individual, corporation, partnership or other.

If a provider is enrolling for the Electronic Health Records (EHR) incentive program and is a member of a group/clinic, but wishes to assign payment to themselves, the W-9 form must contain the taxpayer identification number for you as an individual.

6. Determination of Separate Practice Location Form

This form must be completed and returned if the provider checks “Yes” in either Field 17a or Field 17b of the “Connecticut Medical Assistance Program Enrollment / Re-enrollment Application”.

7. Electronic Funds Transfer (EFT) Form

The Department of Social Services requires that all Connecticut Medical Assistance Program billing providers enroll in and receive claims reimbursement through EFT, unless you are a provider located out-of-state providing approved services to Connecticut Medical Assistance Program clients.

Non-billing providers participating in the Electronic Health Records (EHR) incentive program that wish to assign payment to themselves instead of the group/clinic must complete an EFT form.

If it is a hardship to receive payments via EFT and you elect not to participate in the EFT program, then you may be subject to a per paper check processing fee. Please note that although there is no service charge at this time, this is an option the Department may pursue in the future.

To enroll in EFT, providers must complete and submit an “Authorization for Electronic Funds Transfer” form with a copy of a voided check for a checking account or documentation from your banking institution confirming the bank account and routing number that will be utilized for the EFT deposit. Those providers who are currently enrolled in EFT **are not required to take any action.**

8. Addendum to Provider Enrollment Agreement Concerning the Acceptable Use of Electronic Signatures

This form must be completed in order for DSS to accept electronic signatures to authenticate medical record entries. This form must be completed to indicate that the agreement has been reviewed. Upon receipt, the form will also be signed by an authorized representative of DSS.

9. Deficit Reduction Act Affidavit

Effective January 1, 2007, all “entities” as described in the Deficit Reduction Act are required to comply with the terms of section 1902(a)(68) of the Social Security Act. This attestation form must be completed by all providers that meet the threshold. Submission of an affirmative affidavit is required for enrollment/re-enrollment into the Connecticut Medical Assistance Program.

10. Enrollment Matrix

This form lists all documents that are required for enrollment/re-enrollment. If the required information is not attached, the enrollment/re-enrollment application will be returned to the provider to be completed. This list of additional required documents can also be found on the Web site www.ctdssmap.com. From the Home page, go to Provider → Provider Matrix and scroll down to Additional Evidentiary Documentation. Locate and review the link for your appropriate provider type/specialty.

11. Additional Forms

Based on your provider's type and specialty, there may be some additional forms that you are required to complete and you will find them at the end of this application packet.

IMPORTANT: If the required information is not attached, the enrollment/re-enrollment application will be returned to the provider to be completed. These additional forms can also be found on the Web site www.ctdssmap.com. From the Home page, go to Provider → Provider Matrix and look under "Additional Forms to be Completed".

Providers may review the status of their ATN via the Web site www.ctdssmap.com. From the Home page, go to Provider, Provider Enrollment Tracking, and enter the ATN and last name/business name of the provider. A new provider's application is complete when their status displays "Enrollment Completed". A re-enrolling provider's application is complete when their status is "Reenrollment Complete".

After DSS review and approval, your office will receive a letter confirming your successful enrollment/re-enrollment. If you are denied enrollment, you will be notified of the reason for the rejection.

DSS requires that the completed forms be returned within 30 days to the address listed on the first page of this memorandum. If you have additional questions or need assistance, call the HP Provider Assistance Center at the telephone numbers listed on the first page of this memorandum. Thank you for your cooperation in this enrollment process and participation in the Connecticut Medical Assistance Program.

New providers: The Connecticut Medical Assistance Program Provider Manual and Portable Document Format (PDF) Remittance Advice (RA) is available to view, download, and print from our Web site: www.ctdssmap.com.

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 on both the first and second lines below.

- New Provider or Re-enrollment
- Individual Practitioner or Group Practice/FQHC Clinic or Member of a Group Practice/FQHC Clinic

If Group Practice/FQHC Clinic, Name of Group Practice/FQHC Clinic and NPI should be provided in fields 1 and 4 below.

If Member of a Group/FQHC Clinic, Name and NPI of Group Practice/FQHC Clinic to which you are Requesting Enrollment:

Group/FQHC Clinic Name _____ Group/FQHC Clinic 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

LOCATION B

Address _____

Address _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Contact Name _____ Phone()

Contact Name _____ Phone()

Fax ()

Fax ()

Email Address _____

Email Address _____

Handicap Accessible Y N TTY/TDD()

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

INSTRUCTIONS FOR THE ENROLLMENT/RE-ENROLLMENT FORM

Field Number and Name	Description
ATN:	This field will contain the Application Tracking Number that has been assigned to your enrollment or re-enrollment application.
<i>Section A. Please check as applicable on both the first and second lines below.</i>	
Type of Enrollment (first line):	Using the check boxes, select the applicable type(s) of enrollment.
<input type="checkbox"/> New Provider or	If you are not currently enrolled in the Connecticut Medical Assistance Program, select Enrollment.
<input type="checkbox"/> Re-enrollment	If you are currently enrolled in the Connecticut Medical Assistance Program, select Re-enrollment.
Type of Enrollment (second line):	Using the check boxes, select the applicable type of provider that is enrolling or re-enrolling.
<input type="checkbox"/> Individual Practitioner	An individual provider would be a single individual or entity and is considered the biller and performer of service. Examples include: Single physician office practice, Durable Medical Equipment Supplier.
<input type="checkbox"/> Group Practice/FQHC Clinic or	A provider group consists of more than one performer or member, such as a physician group, dental group, or FQHC Clinic. The provider group would be the billing provider. If the group is enrolling or re-enrolling, the group's provider name and NPI should be listed in fields 1 and 4 in Section B.
<input type="checkbox"/> Member of a Group Practice/FQHC Clinic	A member of a provider group/FQHC Clinic would be a performing provider. The provider group/FQHC Clinic would bill for the services provided by the member/performer of the group. The member that is enrolling must supply the group/FQHC Clinic name and NPI on the lines below the checkbox. The member's name and NPI should be listed in fields 1 and 4 in Section B.
Name of Group Practice/FQHC Clinic:	Enter the name of the group practice or FQHC Clinic, if applicable.

INSTRUCTIONS FOR THE ENROLLMENT/RE-ENROLLMENT FORM

NPI/Non-medical Provider Identifier (s): Enter the NPI/non-medical provider identifier (s) for each of the members of the group or FQHC Clinic. If additional space is needed, please include additional provider identifiers on the Additional Enrollment/Re-enrollment Data Form.

Section B.

1. Provider Name: Enter the name of the provider, either an individual or institution, that is enrolling/re-enrolling.
2. Provider Type: This field displays the numeric value of the provider type of the re-enrolling provider. For new providers, enter the provider type description, i.e., physician, dentist, pharmacy, etc.
3. Provider Specialty: This field displays the numeric value of the provider specialty of the re-enrolling provider. For new providers enter the appropriate provider specialty. For example, Dermatology would be a valid specialty for a Physician.
4. NPI/Non-medical Provider Identifier: This field contains your NPI/non-medical provider identifier. For new non-medical providers, this field should be left blank.
- 4a. Previous NPI/Non-medical Provider Identifier(s) (i.e., ConnPACE, TXIX): Enter any previous NPIs/non-medical provider identifier(s).
5. Medicare Provider Number(s): Enter **all** Medicare provider number(s) to be cross-referenced to the provider number for this application. **The correct cross-referencing of these numbers will allow Medicare to systematically forward coinsurance/deductible claims to HP for processing.** If additional space is required, please use the attached Additional Enrollment/Re-enrollment Data form.
6. Primary Taxonomy: Enter the primary taxonomy of the provider.
- 6a. Taxonomy (list up to four additional) i. – iv. Enter up to four (4) additional taxonomies that are associated with your NPI.
7. Federal Tax ID Number: Enter the FEIN and the effective date used for 1099 reporting or the Social Security Number.

INSTRUCTIONS FOR THE ENROLLMENT/RE-ENROLLMENT FORM

8. State Tax ID Number: (10 digit number) Enter your State Tax ID number and its effective date. A State Tax ID number is required if you have employees or collect state sales tax.
- If neither of these conditions is applicable, you must supply a written statement to this effect on company letterhead and return it with your packet.
9. License/Certification Number and Effective Date: Enter the license or certification number of the provider, if applicable. Enter the effective date of the license or certification number.
10. Clinical Laboratory Improvement Act (CLIA) Number(s): A CLIA number is required if laboratory services are performed. **No claims for laboratory services will be considered for payment unless a valid CLIA number(s) is on file in the provider's record.** Enter the CLIA number(s) associated with the primary service location. If not applicable, enter N/A.
- 11a. Language(s) Enter the language(s) spoken by the provider, including sign language.
- 11b. ADA Accommodations Enter any American Disabilities Act (ADA) accommodations that your location provides, e.g. wheelchair accessible.
12. Provider Primary Service Location Address
- Address: Enter the first line of the provider's primary service location address.
- Address: Enter the second line of the provider's primary service location address.
- Note:** A P.O. Box cannot be accepted as any part of the Service Location address.
- City: Enter the city name of the provider's primary service address.
- State: Enter the state name or abbreviation of the provider's primary service address.
- Zip+ 4: Enter the 9-digit zip code of the provider's primary service address. To obtain the last 4-digits of the zip code, a provider may access the United States Postal Service Web

INSTRUCTIONS FOR THE ENROLLMENT/RE-ENROLLMENT FORM

site at: <http://zip4.usps.com/zip4/welcome.jsp>.

- Contact Name: Enter the name of the contact at the provider's primary service location.
- Phone: The **actual** primary service location telephone number is required in this field. Enter an extension number, if applicable.
- Fax: Enter the fax number for the provider.
- E-mail Address: Enter the e-mail address of the provider.
- Handicap Accessible: Circle Y or N to indicate whether the provider's office is handicap accessible.
- TTY/TDD: Enter your TTY/TDD telephone number, if applicable.
13. Provider Home Office Address Complete these fields if the provider's home office address is different than the primary service location address.
- Address: Enter the first line of the provider's home office address.
- Address: Enter the street name and number of the provider's home office address. This cannot be a P.O. Box.
- City: Enter the city name of the provider's home office address.
- State: Enter the state name or abbreviation of the provider's home office address.
- Zip+ 4: Enter the 9-digit zip code of the provider's home office address.
- Contact Name: Enter the name of the contact at the provider's home office location.
- Phone: Enter the provider's area code and telephone number.
- Fax: Enter the fax number for the provider.
- E-mail Address: Enter the e-mail address of the provider.
- Handicap Accessible: Circle Y or N to indicate whether the provider's office is handicap accessible.

INSTRUCTIONS FOR THE ENROLLMENT/RE-ENROLLMENT FORM

- TTY/TDD: Enter your TTY/TDD telephone number, if applicable.
14. Provider Pay To Address: Complete these fields if the address to which payments should be sent is different from the primary service location address.
- Address: Enter the first line of the provider's pay to address.
- Address: Enter the street name and number of the provider's pay to address.
- City: Enter the city name of the provider's pay to address.
- State: Enter the state name or abbreviation of the provider's pay to address.
- Zip: Enter the 9-digit zip code of the provider's pay to address.
- Contact Name: Enter the name of the contact at the provider's pay to location.
- Phone: Enter the provider's area code and telephone number.
- Fax: Enter the fax number for the provider.
- E-mail Address: Enter the e-mail address for the provider.
15. Provider Mail To Address: Complete these fields if the address to which mail should be sent is different from the primary service location address.
- Address: Enter the first line of the provider's mail to address.
- Address: Enter the street name and number of the provider's mail to address.
- City: Enter the city name of the provider's mail to address.
- State: Enter the state name or abbreviation of the provider's mail to address.
- Zip: Enter the 9-digit zip code of the provider's mail to address.
- Contact Name: Enter the name of the contact at the provider's mail to location.

INSTRUCTIONS FOR THE ENROLLMENT/RE-ENROLLMENT FORM

- Phone: Enter the provider's area code and telephone number.
- Fax: Enter the fax number for the provider.
- E-mail Address: Enter the e-mail address for the provider.
16. (a-b) Alternate Service Locations: You may indicate up to four (4) additional service locations (sometime called practice location) on this application. Use the attached Additional Enrollment/Re-enrollment Data Form for any additional locations.
- Address: Enter the first line of the provider's alternate service location address.
- Address: Enter the street name and number of the provider's alternate service location address.
- City: Enter the city name of the provider's alternate service location address.
- State: Enter the state name or abbreviation of the provider's alternate service location address.
- Zip: Enter the zip code.
- Contact Name: Enter the name of the contact.
- Phone: Enter the telephone number (area code, number, and extension).
- Fax: Enter the fax number for the provider.
- Email Address: Enter the e-mail address for the provider.
- Handicap Accessible: Circle Y or N to indicate whether the provider's office is handicap accessible.
- TTY/TDD: Enter your TTY/TDD telephone number, if applicable.

- 17a. I am a Contractor for an enrolled Medical Assistance Provider. If you are a Contractor of an enrolled Medical Assistance Provider, indicate this with a check in the check box. If the check box is selected, enter the name and NPI/Non-medical provider identifier of the provider with which you are affiliated, provide an unaltered copy of your contract, and complete the Determination of Separate Practice Location Form. If you are not a Contractor of a Medical Assistance Provider, leave this field blank.
- 17b. I am an Employee of an enrolled Medical Assistance Provider. If you are an Employee of an enrolled Medical Assistance Provider, indicate this with a check in the check box. If the check box is selected, enter the name and NPI/Non-medical provider identifier of the provider with which you are affiliated, provide a letter of explanation from your employer, and complete the Determination of Separate Practice Location Form. If you are not an Employee of a Medical Assistance Provider, leave this field blank.
- 17c. If re-enrolling, there has been a substantial change in ownership of my organization. This field is for re-enrolling providers only. If there has been a substantial change in the ownership of your organization, indicate this with a check in the check box. Indicate the nature of the change and the date of the change. If there has been no change, leave this field blank.
18. I have signed the addendum for electronic signatures on medical records. Circle Y or N to indicate whether or not you have signed the addendum attached to this enrollment/re-enrollment packet for electronic signatures on medical records.
19. Provider Signature and Date: Signature of provider or authorized representative. Date the application was signed.
- PRINT NAME and TITLE: Print the name and the title of provider or authorized representative.
20. NPI/Non-medical Provider Identifier: This field should be left blank. It will be completed by HP.
21. Effective Date: This field should be left blank. It will be completed by HP.

INSTRUCTIONS FOR PAGES 2 THROUGH 5

Provide a complete answer to each question. Applicant must answer *Yes* or *No* where required. If a field is not applicable, please indicate. If a question does not apply to you or your organization, enter "N/A." Failure to answer all questions may result in your application being denied.

INSTRUCTIONS FOR PAGE 6

The person who signs the Enrollment and Re-enrollment Form itself, as well as the enclosed Provider Agreement, must also sign this certification. Please print name, date, social security number and position. Failure to complete all of this information may result in your application being denied.

**STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
ENROLLMENT/RE-ENROLLMENT APPLICATION**

PROVIDER NAME: _____

NPI/Non-Medical Provider Identifier: _____

Check One: () Corporation () Estate/Trust () Government Owned () Limited Liability Corp
() Not-for-Profit () Partnership () Public Service Corp () Sole Proprietorship

IF PROVIDER USES A BILLING AGENT OTHER THAN AN ELECTRONIC DATA INTER-CHANGE ENTITY

Name of Billing Agent: _____

Address: _____

City, State, Zip Code: _____

Telephone number(s) (area code first): _____

Social Security Number: _____ Federal Tax ID Number: _____

NAME(S) OF OWNERS AND/OR PARTNERS (Use additional page, if necessary.)

Name: _____	Date of Birth: _____
Address: _____	Social Security Number: _____
City: _____	State: _____ Zip: _____
Telephone number (Area Code): _____	Percentage of ownership: _____

Name: _____	Date of Birth: _____
Address: _____	Social Security Number: _____
City: _____	State: _____ Zip: _____
Telephone number (Area Code): _____	Percentage of ownership: _____

Name: _____	Date of Birth: _____
Address: _____	Social Security Number: _____
City: _____	State: _____ Zip: _____
Telephone number (Area Code): _____	Percentage of ownership: _____

NAMES OF CORPORATE OFFICERS:

PRESIDENT

Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Telephone number: (____)_____

VICE PRESIDENT

Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Telephone number: (____)_____

SECRETARY

Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Telephone number: (____)_____

TREASURER

Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Telephone number: (____)_____

If this corporation is a subsidiary of another company please identify parent corporation

Name: _____ Corporate Headquarters: _____

PROVIDER NAME: _____

ALL PROVIDERS

1. Is or was applicant a Medicaid provider in any other state? Yes [] No []
If yes, list State, Provider Number and Dates.

_____	_____
_____	_____
_____	_____

2. Is applicant a provider for any other federal program (i.e. TRICARE)? Yes [] No []
If yes, list Program and Provider Number.

_____	_____
_____	_____
_____	_____

3. Does applicant contract with any private health insurance providers? Yes [] No []
If yes, list Provider and Contract Number.

_____	_____
_____	_____
_____	_____

4. Are any owners, partners, officers, directors, shareholders or managing employees of applicant related by family or marriage? Yes [] No []
If yes, please identify by name, date of birth, social security number and type of relationship.

5. Are any owners, partners, officers, directors, shareholders or managing employees of applicant related by family, marriage, ownership, control or business relationship to any other provider currently or within the past 5 years enrolled in the Connecticut Medical Assistance Program? Yes [] No []
If yes, please provide name and provider number of provider and name, social security number, date of birth and type of relationship of related party.

6. Does applicant, and/or any owner, partner, officer, director, shareholder or managing employee of provider owe money to the federal government and/or any State for Medicare and/or Medicaid involvement in the past? Yes [] No []

If yes, name debtor, amount owed, to whom the debt is owed and the reason for the debt.

7. Has applicant and/or any owner, associate, partner, officer, director, shareholder or managing employee ever filed bankruptcy on behalf of a business which participated in a State or Federal Medical Assistance Program? Yes [] No []

If yes, please provide date filed, where filed, name filed under, name of associated individual and position with business.

8. Is applicant and/or owner, partner or officer, currently in bankruptcy? Yes [] No []

If yes, provide date filed, where filed, and name filed under.

9. Has there been any disciplinary, administrative, civil or criminal actions taken against applicant, a family member, business associate or managing employee in any way related to the provision of health care services, including but not limited to the provision of Medicare or Medicaid goods or services? Yes [] No [] If yes, please list any and all such actions.

10. Is applicant a salaried employee of a hospital, clinic or institution? Yes [] No []

If yes, are you a full-time or part-time employee? Full -time [] Part-time []

If yes, name the hospital, clinic or institution: _____

11. Does applicant provide contractual services to a hospital, clinic, or institution? Yes [] No []

If yes, name the hospital, clinic or institution: _____

PROVIDER NAME: _____

CERTIFICATION

I hereby certify that the foregoing is true, correct and complete to the best of my knowledge. I certify that I understand that any intentional misstatements in and/or omissions from any of the foregoing responses may constitute a violation of Connecticut General Statutes, as well as grounds for termination of my status as a provider in Connecticut Medical Assistance programs and/or suspension from the Medicaid program.

I further 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 and regulations; to keep accurate and current records regarding the nature, scope and extent of services furnished to Medicaid 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 further certify that I have legal authority to act on behalf of the provider.

(The person signing this certification must be the same person whose signature appears on the Provider Agreement.)

Date

Signature

Name (please print)

Social Security Number

Position

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
HEALTH CARE FINANCING**

PROVIDER ENROLLMENT AGREEMENT

(Name of Applicant)

(hereinafter "Provider") wishes to participate in the Connecticut Medical Assistance Program and, therefore, represents and agrees as follows:

General Provider Requirements

1. To comply continually with all enrollment requirements established under rules adopted by the Connecticut Department of Social Services (hereinafter DSS) or any successor agency, as they may be amended from time to time.
2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.
3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable.
4. To furnish all information requested by DSS specified in this Agreement and the Application Form, and, further, to notify DSS or its designated agent, in writing, of all material and/or substantial changes in information contained on the Application Form.

To furnish material and/or substantial changes in information including changes in the status of Medicare or Medicaid eligibility, provider's license, certification, or permit to provide services in/for the State of Connecticut, and any change in the status of ownership of the Provider, if applicable.

5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.

6. To maintain a specific record for each client eligible for the Connecticut Medical Assistance Program benefits, including but not limited to name; address; birth date; Social Security Number; Connecticut Medical Assistance Program identification number; pertinent diagnostic information including x-rays; current treatment plan; treatment notes; documentation of dates of services and services provided; and all other information required by state and federal law.
7. To maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law or regulation governing record retention, whichever period is greater. In the event of a dispute concerning goods and services provided to a client, or in the event of a dispute concerning reimbursement, documentation shall be maintained until the dispute is completely resolved or for five years, whichever is greater.

The Provider acknowledges that failure to maintain all required documentation may result in the disallowance and recovery by DSS of any amounts paid to the Provider for which the required documentation is not maintained and provided to DSS upon request.

8. To maintain, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d through 1320d-8, inclusive, and regulations promulgated thereto, the confidentiality of client's record, including, but not limited to:
 - a. client's name, address, and Social Security number;
 - b. medical services provided;
 - c. medical data including diagnosis and past medical history;
 - d. any information received for verifying income eligibility;
 - e. any information received in connection with the identification of legally liable third party resources.

Disclosure of clients' personal, financial, and medical information may be made under the following circumstances:

- f. to other providers in connection with their treatment of the client;
- g. to DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;
- h. in connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of or billing for services covered by the Connecticut Medical Assistance Program;
- i. as required to obtain reimbursement from other payer sources;

- j. as otherwise required by state or federal law; and
- k. with the client's written consent to other persons or entities designated by the client or legal guardian, or, in the event that the client is a minor, from the client's parents or legal guardian.

Upon request, disclosure of all records relating to services provided and payments claimed must be made to the Secretary of Health and Human Services; to DSS; and/or to the State Medicaid fraud control unit, in accordance with 42 C.F.R. § 431.300 et seq.

In the event that the Provider authorizes a third party to act on the Provider's behalf, the Provider shall submit written verification of such authorization to DSS.

- 9. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract, and, in accordance with 42 C.F.R. § 455.105 and § 431.115 et seq., to provide upon request of the Secretary of Health and Human Services and/or DSS, full and complete information about the ownership of any subcontractor or any significant business transaction.

No subcontract, however, terminates the legal responsibility of the Provider to DSS to assure that all activities under the contract are carried out. Provider shall furnish to DSS upon request copies of all subcontracts in which monies covered by this Agreement are to be used. Further, all such subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of this Agreement.

- 10. To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted. Receipt of amendments, bulletins and notices by Provider shall be presumed when the amendments, bulletins, and notices are mailed to Provider's current address on file with DSS or its fiscal agent.
- 11. To make timely efforts to determine clients' eligibility, including verification of resources, and to pursue insurance, Medicare and any other third party payor prior to submitting claims to the Connecticut Medical Assistance Program for payment.

Provider further acknowledges the Connecticut Medical Assistance Program as payer of last resort. Provider agrees to exhaust clients' medical insurance resources prior to submitting claims for reimbursement and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

12. To comply with the advance directives requirements set forth specified in 42 C.F.R. Part 489, Subpart I, and 42 C.F.R. § 417.436(d), if applicable.

Billing/Payment Rates

13. To submit timely billing in a form and manner approved by DSS, as outlined in the Provider manual, in an amount no greater than the rates and/or amounts in accordance with those established by the Connecticut Medical Assistance Program, after first ascertaining whether any other insurance resources may be liable for any or all of the cost of the services rendered and seeking reimbursement from such resource(s).
14. To comply with the prohibition against reassignment of provider claims set forth in 42 C.F.R. § 447.10.
15. To submit only claims for goods and services covered by the Connecticut Medical Assistance Program and that are documented by Provider as being:
 - a. for medically necessary medical assistance goods and services;
 - b. for medical assistance goods and services actually provided to the person in whose name the claim is being made;
 - c. for compensation that Provider is legally entitled to receive; and
 - d. in compliance with DSS requirements regarding timely filing.
16. To accept payment as determined by DSS or its fiscal agent in accordance with federal and state statutes and regulations and policies as payment in full for all services, goods, and products covered by Connecticut Medical Assistance Program and provided to program clients.

The Provider further agrees not to bill clients or any other party for any additional or make-up charge for services covered by the Connecticut Medical Assistance Program, excluding any co-payment permitted by law, even when the Program does not pay for those covered services for technical reasons, such as a claim not timely filed or a client being Medicaid managed-care eligible, or a billed amount exceeding the program allowed amount.

The Provider shall refund to the payor any payment made by or on behalf of a client determined to be eligible for Medicaid to the extent that eligibility under the program overlaps the period for which payment was made and to the extent that the goods and services are covered by Medicaid.

17. To timely submit all financial information required under federal and state law.
18. To refund promptly (within 30 days of receipt) to DSS or its fiscal agent any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements.
19. To make repayments to DSS or its fiscal agent, or arrange to have future payments from the DSS program(s) withheld, within 30 days of receipt of notice from DSS or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made. This obligation includes repayment of an overpayment received for prior years or pursuant to prior provider agreements. The Provider is liable for any costs incurred by DSS in recouping any overpayment.
20. To promptly make full reimbursement to DSS or its fiscal agent of any federal disallowance incurred by DSS when such disallowance relates to payments previously made to Provider under the Connecticut Medical Assistance Program, including payments made for prior years or pursuant to prior provider agreements.
21. To maintain fiscal, medical and programmatic records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information will be made available to authorized representatives upon request, in accordance with all state and federal statutes and regulations, including but not limited to 42 C.F.R. § 431.107 including but not limited to, information regarding payments claimed by the Provider for furnishing goods or services.
22. To cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS payments made to Provider, to ensure the proper administration of the Connecticut Medical Assistance Program and to assure Provider's compliance with all applicable statutes and regulations and policies. Such records and information are specified in federal and state statutes and regulations and the Provider Manual and shall include, without necessarily being limited to, the following:
 - a. medical records as specified by Section 1902(a)(31) of Title XIX of the Social Security Act, 42 U.S.C. § 1396a, (hereinafter the "Act") and any amendments thereto;
 - b. original prescriptions for and records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Connecticut Medical Assistance Program, including the authority for and the date of administration of such treatment, drugs, or services;

- c. any original documentation determined by DSS or its representative to be necessary to fully disclose and document the medical necessity of and extent of goods or services provided to clients receiving assistance under the provisions of the Connecticut Medical Assistance Program;
 - d. any other original documentation in each client's record which will enable the DSS or its agent to verify that each charge is due and proper;
 - e. financial records maintained in accordance with generally accepted accounting principles, unless another form is specified by DSS; and
 - f. all other records as may be found necessary by DSS or its agent in determining Provider's compliance with any federal or state law, rule, regulation, or policy.
23. That any payment, or part thereof, for Connecticut Medical Assistance Program goods or services which represents an excess over the appropriate payment or a violation due to abuse or fraud, shall be immediately paid to DSS. Any sum not so repaid may be recovered by DSS in accordance with the provisions below or in an action by DSS brought against the Provider.

Audits and Recoupment

24. That in addition to the above provisions regarding billing and payment, Provider agrees that:
- a. amounts paid to Provider by DSS shall be subject to review and adjustment upon audit or due to other acquired information or as may otherwise be required by law;
 - b. whenever the commissioner of social services renders a decision, whether based upon a field audit or otherwise, which decision results in the Provider being indebted to the DSS for past overpayments, DSS may recoup said overpayments as soon as possible from the DSS's current and future payments to the Provider. DSS's authority to recoup overpayments includes recoupment of overpayments made for prior years or pursuant to prior provider agreements. A recomputation based upon such adjustments shall be made retroactive to the applicable period;
 - c. in a recoupment situation, DSS determine a recoupment schedule of amounts to be recouped from Provider's payments after consideration of the following factors:
 - (1) the amount of the indebtedness;
 - (2) the objective of completion of total recoupment of past overpayments as soon as possible;

- (3) the cash flow of the Provider; and
 - (4) any other factors brought to the attention of DSS by the Provider relative to Provider's ability to function during and after recoupment.
- d. whenever Provider has received past overpayments, the DSS may recoup the amount of such overpayments from the current and future payments to Provider regardless of any intervening change in ownership;
 - e. if Provider owes money to DSS, including money owed for prior years or pursuant to prior provider agreements, DSS or its fiscal agent may offset against such indebtedness any liability to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to DSS was incurred. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this subsection shall apply notwithstanding the form of business organizations utilized by such persons e.g. separate corporations, limited partnerships, etc.; and
 - f. DSS's decision to exercise, or decision not to exercise its right of recoupment shall be in addition to, and not in lieu of, any other means or right of recovery the DSS may have.

Fraud and Abuse; Penalties

- 25. To cease any conduct that DSS or its representative deems to be abusive of the Connecticut Medical Assistance Program; and to promptly correct any deficiencies in Provider's operations upon request by DSS or its fiscal agent.
- 26. To comply with Section 1909 of the Act which provides federal penalties for violations connected with the Medical Assistance Program.

Provider acknowledges and understands that the prohibitions set forth in the Act include but are not limited to:

- a. false statements, misrepresentation, concealment, failure to disclose and conversion of benefits;
- b. any giving or seeking of kickbacks, rebates, or similar remuneration;

- c. charging or receiving reimbursement in excess of that provided by the State;
and
 - d. false statements or misrepresentation in order to qualify as a provider.
27. That termination from participation in the Connecticut Medical Assistance Program will result if the Provider is convicted of a criminal offense as set forth in state or federal law, or by the Medicare Program or Connecticut Medical Assistance Program, and suspension may result if the Provider is so sanctioned by DSS pursuant to statute and regulation for having engaged in fraudulent or abusive program practices or conduct.

Nondiscrimination

28. To abstain from discrimination or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, sex, sexual orientation, mental retardation or physical disability, including but not limited to blindness or payor source, in accordance with the laws of the United States or the State of Connecticut.

Provider further agrees to comply with:

- a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;
- b. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq., (hereafter the “Rehabilitation Act”) as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of the Rehabilitation Act and the regulations, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

- c. Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et seq., as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulations, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any educational program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services; and
- d. the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

Termination

- 29. That this Agreement may be voluntarily terminated as follows:
 - a. by DSS or its fiscal agent upon 30 days written notice; or
 - b. by DSS or its fiscal agent upon notice for Provider's breach of any provision of this Agreement as determined by DSS; or
 - c. by Provider, upon 30 days written notice, subject to any requirements set forth in federal and state law. Compliance with any such requirements is a condition precedent to termination.

Disclosure Requirements

- 30. To comply with all requirements, set forth in 42 C.F.R. §§ 455.100 through 455.106, inclusive, as they may be amended from time to time. These requirements include, but are not limited to, the full disclosure of the following information upon request:
 - a. the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;
 - b. whether any such person is related to another as spouse parent, child, or sibling;
 - c. the name of any other disclosing entity in which such a person also has an ownership or control interest;
 - d. the ownership of any subcontractor with whom Provider has had business transactions totaling more than \$25,000.00 during the 12-month period ending on the date of the request;

- e. any significant business transactions between Provider and any subcontractor during the 5-year period ending on the date of the request; and
- f. any person having an ownership or control interest in Provider, or as an agent or managing employee of Provider, who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs since the inception of these programs.
- g. any other information requested in the Provider Enrollment application.

Provider further agrees to furnish, without a specific request by DSS, the information referenced above at the time of Provider's certification survey and also, without a specific request, disclose the identity of any person with ownership or control interest who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs prior to entering into or renewing this contract in accordance with 42 C.F.R. Part 455.

- 31. That the following penalties set forth in 42 C.F.R. Part 455 are applicable to Providers failing to make that section's required disclosures:
 - a. that DSS is required to either not approve a Provider Agreement or to terminate an existing Agreement if the Provider fails to make the disclosures required by that section; and
 - b. that federal financial participation is not available to Providers that fail to disclose the information required by that section; and
 - c. that DSS may refuse to enter into or renew an Agreement with a Provider if any person with ownership or management control, or an agent or a managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program; and
 - d. that DSS may refuse to enter into or may terminate a Provider Agreement if it determines that a Provider did not fully and accurately make the required disclosures concerning such convictions.

Miscellaneous

32. That this Agreement, upon execution, supersedes and replaces any Provider Agreement previously executed by the Provider. This Agreement does not impair Provider's obligation to repay to DSS any money owed to DSS pursuant to prior Provider agreements or the ability of DSS to recoup such amounts from payments made pursuant to this Agreement.
33. In the event that the Provider has been furnished with point of sale devices by DSS, such devices is to be returned to the DSS or its agent upon demand of DSS. If a provider refuses to return such devices the DSS may deduct the cost of the DSS-owned devices from any funds due the Provider, including future payments.
34. The Provider acknowledges that there is no right to renew this Agreement.
35. The Provider will examine publicly available data, including but not limited to the Centers for Medicare and Medicaid Services (hereafter "CMS"), or any successor agency, Medicare/Medicaid Sanction Report and the CMS Web site, to determine whether any potential or current employees have been suspended or excluded or terminated from the programs and shall comply with, and give effect to, any such suspension, exclusion, or termination in accordance with the requirements of state and federal law.

The effective date of this Agreement is _____. This Agreement shall thereafter be in effect for a period of _____, ending _____ unless terminated by either party prior to the stated ending date.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO \$25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Provider Entity Name (doing business as);

Name of Authorized Representative (typed) (Must be an Authorized Officer, Owner, or Partner):

Signature: _____ Date:

Title: Commissioner

Date of Signature:



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET λ HARTFORD, CONNECTICUT 06106-5033

NOTICE TO PROVIDERS

Section 1128B of the Social Security Act provides Federal penalties for violations connected with the Medical Assistance Program.

The Act prohibits:

- 1. False statements, misrepresentation, concealment, failure to disclose and conversion of benefits;**
- 2. Any giving or seeking of kickbacks, rebates, or similar remuneration;**
- 3. Charging or receiving reimbursement in excess of that provided by the State;**
- 4. False statements or misrepresentation in order to qualify an institution as a provider.**

Any person committing any such acts or making such statements shall be guilty of felony and upon conviction fined not more than \$25,000.00 or imprisoned for not more than five years, or both.

In addition, pursuant to Sec. 1128A of the Social Security Act, any person or entity that causes to be presented a claim for medical item or service the claimant knows or has reason to know was not provided as claimed or payment for which may not be made under the program, or caused to be presented a request for payment which is in violation of the terms of any assignment or an agreement, shall be subject to a civil money penalty of not more than \$2,000.00 for each item or service and an assessment of not more than twice the amount claimed for each such item or service.

Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____	
	<input type="checkbox"/> Other (see instructions) ▶ _____	
Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)																						
Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.																						
	<table border="1" style="margin: auto;"> <tr> <th colspan="10">Social security number</th> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>	Social security number																				
Social security number																						
Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.																						
	<table border="1" style="margin: auto;"> <tr> <th colspan="9">Employer identification number</th> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>	Employer identification number																				
Employer identification number																						

Part II Certification			
Under penalties of perjury, I certify that:			
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and			
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and			
3. I am a U.S. citizen or other U.S. person (defined below).			
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.			
Sign Here	<table style="width: 100%;"> <tr> <td style="width: 70%;">Signature of U.S. person ▶</td> <td style="width: 30%;">Date ▶</td> </tr> </table>	Signature of U.S. person ▶	Date ▶
Signature of U.S. person ▶	Date ▶		

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name" sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.
² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. **Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.
2. **Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.
3. **Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



Determination of Separate Practice Location

- 1. Does the provider have an address which is the same as the address of the hospital, institution, group, or clinic?**
- 2. Does the provider have a tax ID which is the same as the hospital, institution, group, or clinic?**
- 3. Are any of the staff working with the provider, such as nurses, physician assistants, or support staff, shared with or employed by the hospital, institution, group, or clinic?**
- 4. Does the provider share, or have the use of, any space which belongs to the hospital, institution, group, or clinic (i.e. space which is not leased from the hospital, institution, group, or clinic)?**
- 5. Is there a subsidy of any type to or from the hospital, institution, group, or clinic?**

Electronic Funds Transfer (EFT) Mandate for Reimbursement of Connecticut Medical Assistance Program Services

The Department of Social Services (DSS) requires all providers to participate in electronic funds transfer (EFT), with the exception of providers located out-of-state providing approved services to Connecticut Medical Assistance Program clients. However, if it is a hardship to do so and you elect not to participate in the EFT program, then you may be subject to a per paper check processing fee. Please note that although there is no service charge at this time, this is an option the Department may pursue in the future. EFT is a more efficient and cost effective means of reimbursement for Connecticut Medical Assistance Program services. The EFT form located on the next page must be completed and returned to HP with this enrollment/re-enrollment application.

Note: Providers who are currently enrolled in EFT do not need to take any action if their EFT data is to remain the same.

The EFT process will take approximately four to six weeks to be completed. Providers will have an initial EFT status of pre-notification, at which time HP will send a test EFT transaction to the Bank of America. During this time, providers will receive a paper check. Providers will remain in this status until a successful pre-notification transaction has been confirmed. Once a successful transaction is made, providers will begin to receive their funds via EFT beginning with the next claims processing cycle. The first time a paper check is not received, providers should confirm with their bank that an EFT has been made.

Providers must inform HP of any changes to their bank account (i.e. account number, ABA number) by submitting an updated “Authorization for Electronic Funds Transfer” form to the HP Provider Enrollment Unit at P.O. Box 5007, Hartford, CT 06104. Updates to this data may also be made at www.ctdssmap.com. This action will place the provider in a pre-notification status and the provider will once again receive a paper check until a successful pre-notification transaction has been confirmed. Failure to inform HP of a change to your bank account information may result in a delay in receiving your paper check.

The ASC X12N 835, Electronic Remittance Advice, will include EFT information. The financial information segment (BPR) will include the following fields:

BPR05 - Payment Code = “CCP”	BPR10 - DSS EIN Number
BPR06 – ID Qualifier Number = “01”	BPR12 - Depository Financial Institution Identification Number Qualifier = “01”
BPR07 - Bank ABA Routing Number	BPR13 - Receiver or Provider Bank ID Number
BPR08 - Account Number Qualifier = “DA”	BPR14 - Type of account
BPR09 - DSS Bank Account Number	BPR15 - Receiver or Provider Account Number

Connecticut Medical Assistance Program Authorization for Electronic Funds Transfer (EFT)

Complete the section below and attach a copy of a voided check for a checking account or documentation from your banking institution confirming the bank account and routing number that will be utilized for the EFT deposit. The bank transit routing number, also known as the American Banking Association (ABA) routing number can be obtained from your bank. The ABA routing number is a nine (9) digit number.

An AVRS ID is issued when a provider successfully enrolls into the Connecticut Medical Assistance Program. If you are a newly enrolling provider, please leave this field blank. If you are a re-enrolling provider, your AVRS ID can be found on your initial Welcome Letter that you received at the time of enrollment or on the Banner Page of your Remittance Advice.

Type of Authorization	NEW _____ CHANGE _____
AVRS ID	PROVIDER NAME
BANK NAME	BANK TRANSIT ROUTING/ABA NUMBER
ACCOUNT NUMBER	TYPE OF ACCOUNT
	CHECKING _____ SAVINGS _____

I agree to keep, and disclose upon request to authorized agencies, records that disclose fully the extent of payments claimed from the services rendered to clients of the Connecticut Medical Assistance Program. I accept as payment in full the amount paid by the Connecticut Medical Assistance Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Connecticut Medical Assistance Program payments made to the above provider number(s). I understand that I am responsible for the validity of the above information.

Contact Name

Address

Email Address

Signature

Date

Return this form to:
HP
P.O. Box 5007
Hartford, CT 06104

Please Note: Connecticut Medical Assistance Program providers who are currently enrolled in EFT are not required to complete this form.

**CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
HEALTH CARE FINANCING
ADDENDUM TO PROVIDER ENROLLMENT AGREEMENT
CONCERNING THE ACCEPTABLE USE OF ELECTRONIC SIGNATURES**

For documentation purposes, signatures are used to identify the person who made the entry, to indicate that a review of an entry has been made, and to designate approval of an entry in a medical record. In recognition of the increased use of electronic signatures by Providers, the Department of Social Services (“DSS”) will accept electronic signatures to authenticate medical record entries, as long as Providers: (1) create, maintain, follow and update written policies that, at a minimum, meet the conditions set forth in this Addendum, and (2) sign this Addendum, which has also been signed by an authorized representative of DSS.

For purposes of this Addendum, (1) an “electronic signature” refers to an electronic sound, symbol or process attached to, or logically associated with, a record that is executed or adopted by a person with the intent to sign the record; and (2) “authenticate” refers to a means to identify the author of medical record entries and confirm that the contents are what the author intended.

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:

1. 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.
2. Before assigning the unique code, the Provider shall verify the identity of the User.
3. The unique code assigned by the Provider to a User shall not be assigned to anyone else.
4. 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.

Addendum to Provider Enrollment Agreement Concerning the Acceptable Use of Electronic Signatures

5. 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.
6. 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.
7. The Provider who uses electronic signatures based upon use of identification codes in combination with passwords, as described above, shall use the following additional controls to ensure the security and integrity of each User's electronic signature:
 - (a) Ensure that no two Users have the same combination of identification components (such as identification code and password);
 - (b) Ensure that passwords are revised periodically, and no less often than every 60 days, except as otherwise agreed to in writing by DSS;
 - (c) Follow loss management procedures to electronically deauthorize lost, stolen, missing or otherwise compromised documents or devices that bear or generate identification code or password information and use suitable, rigorous controls to issue temporary or permanent replacements;
 - (d) Use safeguards to prevent the unauthorized use or attempted use of passwords and/or identification codes; and
 - (e) Test or use only tested devices, such as tokens or cards that bear or generate identification code or password information to ensure that they function properly and have not been altered.

If a Provider uses electronic signatures based on two (2) components that are other than identification codes in combination with passwords, the Provider shall use the additional controls as set forth in (a) through (e) of this paragraph as applicable to those identification components.

8. Providers must use a secure, computer-generated, time-stamped audit trail that records independently the date and time of User entries, including actions that create, modify or delete electronic records. Record changes shall not obscure previously recorded information. Audit trail documentation shall be retained for a period at least as long as that required for the medical record and shall be available to DSS for review and copying.

Addendum to Provider Enrollment Agreement Concerning the Acceptable Use of Electronic Signatures

I hereby certify that the Provider has policies that meet the above-stated requirements for acceptance of electronic signatures by DSS, and that the Provider meets all of the above-stated requirements for the issuance and use of electronic signatures.

Printed Name of Provider

NPI/Non-medical Provider Identifier

Printed Name of Performing Provider, if applicable

Performing Provider NPI/Non-medical Provider Identifier, if applicable

Printed Name and Title of Authorized Representative of Provider

Signature of Authorized Representative of Provider

Date

.....

Printed Name of Authorized Representative of DSS

Date

Signature page should be returned with this enrollment/re-enrollment packet to:

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

Section 6032 of the Deficit Reduction Act

Section 6032 of the Deficit Reduction Act (DRA) established section 1902(a)(68) of the Social Security Act. Effective January 1, 2007, all “entities” as described in the Act were required to comply with the terms of this section. The term “entity” includes, but is not limited to a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which furnishes directly, or otherwise authorizes the furnishing of, the delivery of Medicaid health services where payments are made with respect to those services are received or made under a State Plan approved under Title XIX or under any waiver of such plan approved under section 1115, and total at least \$5,000,000 during the most recent federal fiscal year.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

If you or your organization meets the definition of an “entity” under this section as determined by payments received during the federal fiscal year ended September 30, 2006, you are required to establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity’s policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also provide specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity’s policies and procedures for detecting and preventing waste, fraud, and abuse.

Any entity that meets the \$5,000,000 threshold must provide to the Department of Social Services (DSS) an affidavit stating that it understands the requirements of section 1902(a)(68) and that it has provided and continues to make available to its employees, contractors and agents written policies that fully address the requirements of the section. The written policies must be available for review by DSS. Failure to submit an affirmative affidavit or to comply with the requirements of section 1902(a)(68) will result in termination of the entity’s provider agreement with DSS.

You are strongly advised to consult the language in Section 1902(a)(68) of the Social Security Act (Section 6032 of the DRA). For reference please see www.ssa.gov/OP_Home/ssact/title19/1902.htm.

In addition to the education requirements regarding the False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act, an entity shall reference the following Connecticut State Statutes and Regulations in their employee policies:

Criminal:

- Conn. Gen. Stat. Sec. 53a-290 et seq. (Vendor Fraud)
- Conn. Gen. Stat. Sec. 53-440 et seq. (Health Insurance Fraud)
- Conn. Gen. Stat. Sec. 53a-118 et seq. (Larceny)
- Conn. Gen. Stat. Sec. 53a-155 (Tampering With Or Fabricating Physical Evidence)
- Conn. Gen. Stat. Sec. 53a-157b (False Statement Intending to Mislead Public Servant)

Fraud:

Conn. Gen. Stat. Sec. 17b-25a (Toll free vendor fraud telephone hotline)
Conn. Gen. Stat. Sec. 17b-99 (Vendor Fraud)
Conn. Gen. Stat. Sec. 17b-102 (Financial Incentive for Reporting Vendor Fraud)
Regs. Conn. State Agencies Sec. 17-83k-1 et seq. (Administrative Sanctions)
Regs. Conn. State Agencies Sec. 17b-102-01 et seq. (Financial Incentive for Reporting Vendor Fraud and Requirements for Payment for Reporting Vendor Fraud)

Whistleblower Protections:

Conn. Gen. Stat. Sec. 4-61dd (Whistleblowing)
Conn. Gen. Stat. Sec. 31-51m (Protection of Employee Who Discloses Employer's Illegal Activities or Unethical Practices)
Conn. Gen. Stat. Sec. 31-51q (Liability of Employer for Discipline or Discharge of Employee on Account of Employee's Exercise of Certain Constitutional Rights)
Regs. Conn. State Agencies Sec. 4-61dd-1 et seq. (Rules of Practice for Contested Case Proceedings under the Whistleblower Protection Act)

Please sign the affidavit below and return it with this enrollment/re-enrollment packet.

ATTESTATION Re: Section 6032 of the Deficit Reduction Act

**To: Quality Assurance Division
Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033**

I, _____ [name of entity's authorized representative], hereby swear or attest, under the penalty for false statement, that in my capacity as _____ [position or office held by entity's authorized representative] of _____ [name of entity] I have the authority to make this attestation on behalf of _____ [name of entity] and have attached appropriate documentation proving that I possess such authority. _____ [name of entity] has complied with all applicable requirements of § 1902(a)(68) of the Social Security Act (42 U.S.C. 1396a(a)(68)) and §§ 17b-262-770 through 17b-262-773 of the Regulations of Connecticut State Agencies.

_____ Date: _____
[name of entity's authorized representative]

State of _____
County of _____

On this the _____ day of _____, _____, before me, _____, the undersigned officer, personally appeared _____ [name of entity's authorized representative], who acknowledged herself/himself to be the _____ [position or office held by entity's authorized representative] of _____ [name of entity], a _____ [business form of entity, e.g., partnership, corporation, etc.], and that she/he, as such _____ [position or office held by entity's authorized representative], being authorized so to do, executed the foregoing attestation for the purposes therein contained, by signing the name of _____ [name of entity] by herself/himself as _____ [position or office held by entity's authorized representative], and swore or attested to the truth of the above attestation.

In witness whereof I hereunto set my hand

Notary Public/Justice of the Peace/ Commissioner of the Superior Court

FALSE STATEMENT IS PUNISHABLE BY A FINE NOT TO EXCEED \$1,000.00,
IMPRISONMENT FOR NOT MORE THAN ONE YEAR, OR BOTH. CONN. GEN. STAT. § 53A-15