This packet contains information that will help guide ODP providers through the PROMISe™ Provider Enrollment Process.

Use the following links to go directly to the document you would like to view:

PROMISe™ Provider Enrollment Base Application Instructions

Print the Provider Enrollment Base Application from the DHS website. Use only the application on the website. This means visit the website every time before submitting an application, as changes occur frequently and **out of date applications will not be accepted.**

To download the application:

1. Navigate to http://www.dhs.pa.gov/
2. Click **Provider**s at the top of screen
3. Click on **More**
4. Locate the **PROMISe** hyperlink and click **Enrollment Information**
5. Navigate to your Provider Type
6. Click the **Enrollment Application/Provider Agreement** hyperlink to open the document

IMPORTANT NOTES:

- **Applications must be typed or completed by hand using black ink.**
- **Complete ALL SPACES as required on the application with either your correct information, or N/A. If a question requires a Yes or No answer, DO NOT answer N/A.**
- **The application must be printed and submitted as a single-sided document.**

Specific Field Completion Instructions

Field	Description and Completion Notes
1.	Enter the complete name of the individual or the facility. **NOTE:** The facility name cannot include a street address.
2a.	If this is an **Initial Enrollment** check the box and select **Individual** or **Facility**. Write the MPI and service location on the right side of the box. **NOTE:** For each unique service location, a new application must be completed.
2b.	If this is a **REVALIDATION** please check the box and select **Individual** or **Facility**. Write the MPI and Service location # on the right side of the box.
2c.	If you are re-activating a closed service location that was enrolled in PROMISe™ in the past, check this box and enter your nine (9) digit **MPI number** and four (4) digit **service location code.**
2d.	Complete this section by filling in **MPI** and **SLC ONLY** if adding an Individual to your group
3.	**IMPORTANT:** This cell **must be completed** for all healthcare provider types 05, 16, 17, 19, 21, or 52 (with specialties 456 or 520). Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the health care provider applying for enrollment. Enter your ten (10) digit NPI number, and ten (10) digit taxonomy code(s). If you have more than four (4) taxonomy codes, please attach an additional sheet noting the additional codes.

Field	Description and Completion Notes
	NOTE FOR PROVIDER TYPE 26, 51, 52 (for specialties, 521, 522, and 524), 53, 54 and 55: These provider types are considered an atypical (non-healthcare) provider type; therefore, no NPI is needed. **NOTE FOR PROVIDER TYPE 21:** This provider type needs to coordinate changes with the ODP Case Management lead when providing this service for the office of Developmental Programs. There are changes that **must** take place in HCSIS for claims to process correctly.
4.	Enter the requested effective date for your action request. Date must meet qualification requirements and licensing eligibility (if applicable). Leave blank for **REVALIDATIONS**. **NOTE:** If claims are submitted in PROMISe™ using a date prior to the approved Requested Effective Date, they will be denied
5.	Enter your provider type number and description. (See chart following these online instructions)
6.	Enter your specialty name and code number.
7.	Enter another specialty here, if applicable or enter N/A.
8.	Enter another specialty here, if applicable or enter N/A.
9.	Enter your Social Security Number (SSN) **IF** you are enrolling as an individual. **NOTES:** • A copy of your **Social Security card, W-2, or document from (generated by) the IRS** containing your Social Security Number must accompany your application. • If you complete this field, do not complete # 10.
10.	Enter your Federal Tax ID Number (FEIN) **IF** you are enrolling as an agency. **NOTES:** • A copy of the FEIN label or document from the IRS containing your FEIN number must accompany this application. A W-9 form will **not** be accepted. • If you complete this field, do not complete #9.
11.	Enter your legal name as it is filed with the IRS and as it appears on the attached IRS documentation. It is not necessary that **Facility Name** in #1 and **Legal Name** in #11 match; *however*, the Legal Name in #11 MUST match the name on the IRS documentation.
12a.	Indicate whether the provider participates with any PA MCOs.
12b.	If 'Yes' is checked, please list the MCO(s).
13a.	Indicate whether the provider operates under a fictitious business or “doing business as” (d/b/a) name.
13b.	If applicable, enter the statement/permit number and the name. **NOTE:** Attach a legible copy of the recorded/stamped fictitious business name statement/permit from the Department of State.
14.	For Individuals Only: Enter your date of birth.
15.	For Individuals Only: Enter your gender.
16.	For Individuals Only: Enter the title/degree you currently hold.

Field	Description and Completion Notes
17a.	Enter your legal entity address. A post office box is not a valid legal entity address. The zip code **must** contain all nine (9) digits.
17b.	Enter the name of the CEO, President or Owner of the organization.
17c.	Enter the e-mail address for the contact person listed in # 17b, if applicable.
17d.	Enter the business phone for the contact person listed in # 17b.
17e.	Enter the toll free business phone for the contact person listed in # 17b, if applicable.
17f.	Enter the fax number for the contact person listed in # 17b, if applicable.
18.	Select the appropriate box for your business type. Check only one box.
19.	If you are enrolling to provide a licensed service, enter your license number, issuing state, issue date, and expiration date. **NOTE:** A copy of your license or certificate of compliance must accompany your application. Attach the page of the license that pertains to the service location.
20.	Enter **N/A**.
21.	Answer yes or no. N/A is **not** an acceptable answer.
22.	Enter CMS certification # if applicable **OR** enter N/A
23a.	Enter a valid service location address. This address should already be entered in HCSIS and the addresses should match. Select **Pay-to, Mail-to** and/or **Home Office**, if applicable **NOTES:** • The address must be a physical location, not a post office box. • The zip code MUST contain all nine (9) digits. • For **Pay-to, Mail-to,** and/or **Home Office** locations different from the Service Location address entered in # 23a, complete the additional Home Office/Mail-To/Pay-To page within the application. If the **Pay-to, Mail-to** and/or **Home Office** are all the same as the Service Location address, write **N/A** on the additional page. • Make sure ALL questions are answered **Yes** or **No**. • Rural Health Clinic and questions regarding previous screenings **MUST** be answered
23b.	Indicate whether you want to receive electronic bulletin notifications and provide an email address if you do.
23c.	Check box or write **N/A**.
23d.	Enter the PROMISe™ billing contact for your organization.
23e.	Enter the toll free business phone for the contact person listed in # 23d, if applicable.
23f.	Enter the fax number for the contact person listed in # 23d, if applicable.
23g.	Enter the e-mail address for the contact person listed in # 23d.
23h.	Select whether you or your staff are able to communicate in any language other than English. **NOTE:** American Sign Language (ASL) is considered another language.
23i.	List the language(s), other than English, in which you or your staff are able to communicate.
23j.	Enter the appropriate Provider Eligibility Program(s) (PEP) in which you participate. Follow the instructions below: • Enter Consolidated, P/FDS and ID Base for all Provider Types. If you do not provide waiver services, **enter ID Base only**.

	Description and Completion Notes
24.	The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions. **Note:** If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application
25.	Sign the form and print your name, title, and date **(The signature should be that of the individual applying for enrollment or someone able to represent the facility applying for enrollment).**
26.	Use this page only to add a Mail-to, Pay-to and/or Home Office address to the previously defined service location entered in # 23a.
Page 18	**N/A** Does not need to be submitted
Page 19	Enter provider name
Page 20	Sign the Provider Agreement and print your name, title, and date **(The signature should be that of the individual applying for enrollment or someone able to represent the facility applying for enrollment).**
21 & 22	These definitions are to provide clarification for the following pages. They do not need to be submitted with your application.
Page 23	Both top and bottom sections must be completed. If there is more than 1 managing employee or agent, make additional copies of page 23
24 - 29	**Section II** includes pages 24 through 29. Any provider who is incorporated, whether for profit or not for profit must complete pages **24** and **25** for every owner or not for profit board member. Also answer question B (page 26) through question G (page 29). If these questions are not applicable, write N/A. However, please note that questions **F** and **G** require a Y or N answer. Do **not** mark them N/A.

Additional Notes:

- Review the PROMISe™ Provider Enrollment Packet Checklist before submitting your application.
- **Page 18 should be omitted** when submitting your application. It cannot be used to enroll additional service locations for our department.
- **All providers MUST sign and date Pages 16** and **Page 20,** the Provider Agreement for Outpatient Providers.
- Return your application and other documentation to:

ODP Provider Enrollment
625 Forster St
Room 413
Health & Welfare Building
Harrisburg, PA 17120

Contact Information	
E-Mail Address:	**ra-odpproviderenroll@pa.gov**
Fax Number:	**717-783-5141**
Phone Number**:**	1-888-565-9435

ODP Provider Types and Specialty Codes

Provider Type	Description	Specialty Code	Description
03	Extended Care Facility	036	Respite Care
05	Home Health	051	Private Duty Nurse
16	Nurse	160	Registered Nurse
		161	Licensed Practical Nurse
17	Therapist	170	Physical Therapist
		171	Occupational Therapist
		173	Speech/Hearing Therapist
19	Psychologist	208	Behavioral Therapist Consultant
21	Case Management	218	MR Case Management
26	Transportation	267	Non-emergency
43	Homemaker Agency	430	Homemaker Agency
		431	Homemaker/Chore Services
51	Home & Community Habilitation	362	Attendant Care / Persl Asst Serv (cnsr model agcy)
		363	Companion Service
		410	Adult Day Services
		430	Homemaker Agency
		431	Homemaker / Chore Services
		508	Behavioral Support
		509	Supports Broker Services
		510	Home and Community Habilitation
		512	Respite Care – Home Based
		513	Respite Care – Out of Home
		514	Adult Training – 2380
		515	Pre-Vocational – 2390
		516	Transitional Work Services
		517	Visual & Mobility Therapy
		519	FSS/Consumer Payment
52	Community Residential Rehabilitation	456	CRR-Adult
		520	Child Residential Services – 3800
		521	Adult Residential – 6400
		522	Family Living Homes – 6500
		524	Unlicensed
53	Employment – Competitive	530	Job Finding
		531	Job Support
54	Intermediate Service Organization	540	ISO – Agency with Choice
		541	ISO – Fiscal/Employer Agent

ODP Provider Types and Specialty Codes (Continued)

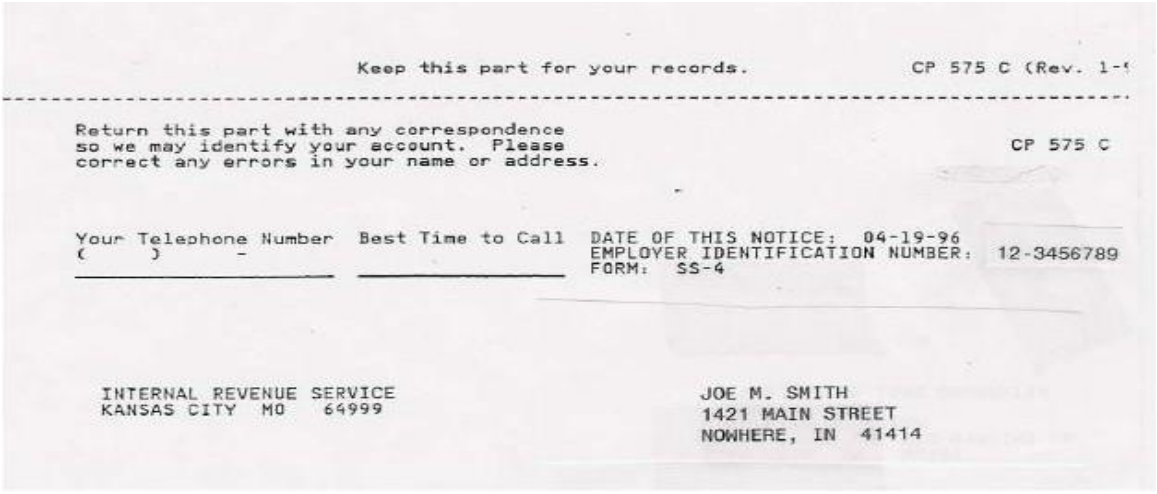
Provider Type	Description	Specialty Code	Description
55	Vendor	267	Non-emergency
		430	Homemaker Agency
		519	FSS/Consumer Payment
		533	Educational Service
		543	Environmental Accessibility Adaptations
		552	Adaptive Appliances/Equipment
		553	Habilitation Supplies
		554	Respite, Overnight Camp
		555	Respite, Day Camp

Examples of Acceptable Documentation to Verify IRS Numbers

The following documents are acceptable as verification of the FEIN/SSN number:

NOTE: Only the applicable portions of the documents have been included.

- **IRS Form CP575**



Keep this part for your records. CP 575 C (Rev. 1-

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address. CP 575 C

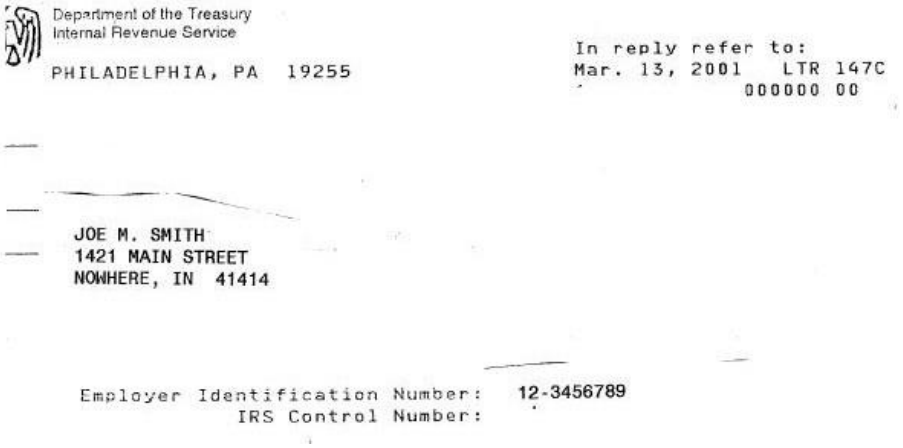
Your Telephone Number ( ) - _____ Best Time to Call _____

DATE OF THIS NOTICE: 04-19-96
EMPLOYER IDENTIFICATION NUMBER: 12-3456789
FORM: SS-4

INTERNAL REVENUE SERVICE
KANSAS CITY MO 64999

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

- **IRS Letter 147C**



Department of the Treasury
Internal Revenue Service
PHILADELPHIA, PA 19255

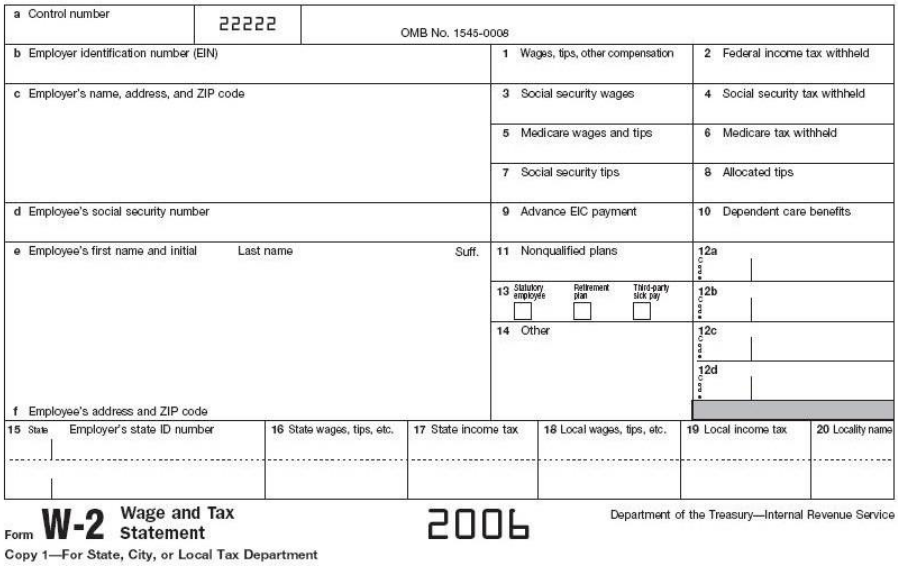
In reply refer to:
Mar. 13, 2001 LTR 147C
000000 00

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

Employer Identification Number: 12-3456789
IRS Control Number:

- **Social Security Card**

- **Form W-2**



a Control number	22222	OMB No. 1545-0008		
b Employer identification number (EIN)			1 Wages, tips, other compensation	2 Federal income tax withheld
c Employer's name, address, and ZIP code			3 Social security wages	4 Social security tax withheld
			5 Medicare wages and tips	6 Medicare tax withheld
			7 Social security tips	8 Allocated tips
d Employee's social security number			9 Advance EIC payment	10 Dependent care benefits
e Employee's first name and initial	Last name	Suff.	11 Nonqualified plans	12a
			13 Statutory employee / Retirement plan / Third-party sick pay	12b
			14 Other	12c
				12d
f Employee's address and ZIP code				

15 State Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name

Form **W-2** Wage and Tax Statement — 2006 — Department of the Treasury—Internal Revenue Service

Copy 1—For State, City, or Local Tax Department

- **Social Security Statement (MUST include BOTH pages 1 & 2)**

Page 1:

Prevent identity theft—protect your Social Security number

Your Social Security Statement

Prepared especially for Wanda Worker

January 6, 2006

See inside for your personal information →

WANDA WORKER
456 ANYWHERE AVENUE
MAINTOWN, USA 11111-1111

What's inside…

Page 2:

*Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law governing benefit amounts may change because, by 2041, the payroll taxes collected will be enough to pay only about 74 percent of scheduled benefits.

We based your benefit estimates on these facts:

Your date of birth	May 5, 1965
Your estimated taxable earnings per year after 2005	$37,276
Your Social Security number (only the last four digits are shown to help prevent identity theft)	XXX-XX-1234

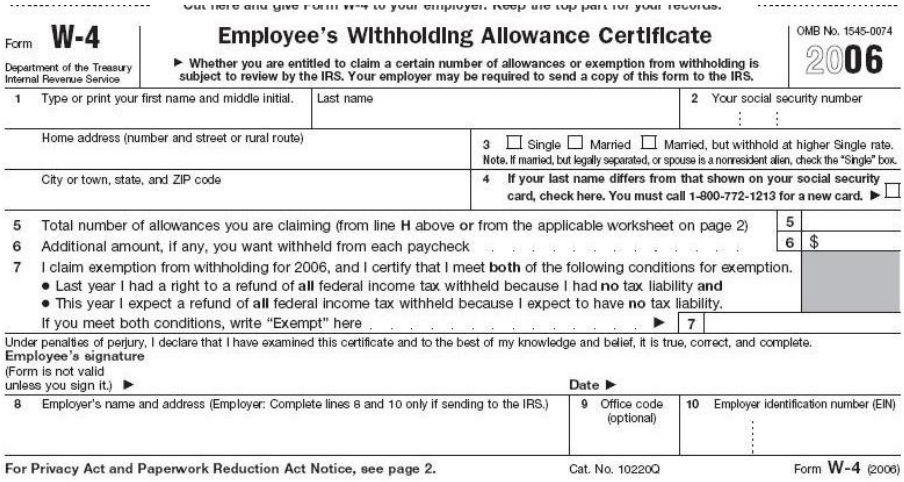
2

Examples of Unacceptable Documentation to Verify IRS Numbers

The following documents are **NOT** acceptable as verification of the IRS/SSN number:

NOTE: Only the applicable portions of the documents have been included.

- **Form W-4**



Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074 — 2006

1 Type or print your first name and middle initial. | Last name | 2 Your social security number

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ► ☐

5 Total number of allowances you are claiming (from line **H** above or from the applicable worksheet on page 2) — 5

6 Additional amount, if any, you want withheld from each paycheck — 6 $

7 I claim exemption from withholding for 2006, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here ► 7

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ► Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form W-4 (2006)

- **Form W-9**

Form **W-9** (Rev. November 2005) — Department of the Treasury, Internal Revenue 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, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ☐ Exempt from backup withholding

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 Line 1 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 *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number — or — Employer identification number

- **Form SS-5 (Application for a Social Security Card)**

SOCIAL SECURITY ADMINISTRATION
Application for a Social Security Card

Form Approved
OMB No. 0960-0066

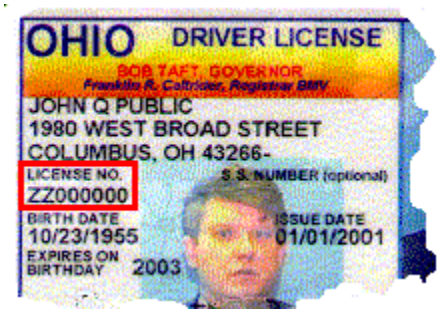
1	NAME TO BE SHOWN ON CARD	First	Full Middle Name	Last
	FULL NAME AT BIRTH IF OTHER THAN ABOVE	First	Full Middle Name	Last
	OTHER NAMES USED			
2	MAILING ADDRESS (Do Not Abbreviate)	Street Address, Apt. No., PO Box, Rural Route No.		
		City	State	ZIP Code
3	CITIZENSHIP (Check One)	☐ U.S. Citizen	☐ Legal Alien Allowed To Work	☐ Legal Alien **Not** Allowed To Work (See Instructions On Page 2) ☐ Other (See Instructions On Page 2)
4	SEX	☐ Male	☐ Female	
5	RACE/ETHNIC DESCRIPTION (Check One Only - Voluntary)	☐ Asian, Asian-American or Pacific Islander	☐ Hispanic	☐ Black (Not Hispanic) ☐ North American Indian or Alaskan Native ☐ White (Not Hispanic)
6	DATE OF BIRTH	Month, Day, Year		
7	PLACE OF BIRTH (Do Not Abbreviate)	City	State or Foreign Country	Office Use Only FCI
8	A. MOTHER'S NAME AT HER BIRTH	First	Full Middle Name	Last Name At Her Birth
	B. MOTHER'S SOCIAL SECURITY NUMBER (See instructions for 8B on Page 2)	___-___-____		
9	A. FATHER'S NAME	First	Full Middle Name	Last
	B. FATHER'S SOCIAL SECURITY NUMBER (See instructions for 9B on Page 2)	___-___-____		
10	Has the applicant or anyone acting on his/her behalf ever filed for or received a Social Security number card before?	☐ Yes (If "yes", answer questions 11-13.)	☐ No (If "no," go on to question 14.)	☐ Don't Know (If "don't know," go on to question 14.)
11	Enter the Social Security number previously assigned to the person listed in item 1.	___-___-____		
12	Enter the name shown on the most recent Social Security card issued for the person listed in item 1.	First	Middle Name	Last
13	Enter any different date of birth if used on an earlier application for a card.	Month, Day, Year		
14	TODAY'S DATE	Month, Day, Year		
15	DAYTIME PHONE NUMBER	( ) –		
		Area Code	Number	
16	I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. YOUR SIGNATURE			
17	YOUR RELATIONSHIP TO THE PERSON IN ITEM 1 IS:	☐ Self	☐ Natural Or Adoptive Parent	☐ Legal Guardian ☐ Other (Specify)

DO NOT WRITE BELOW THIS LINE (FOR SSA USE ONLY)

NPN			DOC	NTI	CAN		ITV
PBC	EVI	EVA	EVC	PRA	NWR	DNR	UNIT
EVIDENCE SUBMITTED					SIGNATURE AND TITLE OF EMPLOYEE(S) REVIEWING EVIDENCE AND/OR CONDUCTING INTERVIEW DATE DCL DATE		

Form SS-5 (12-2005) ef (12-2005) Destroy Prior Editions Page 5

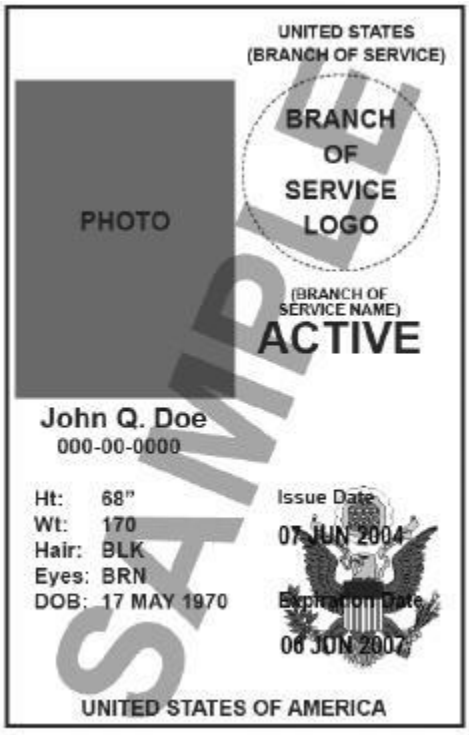
- **State Driver's License**



- **Military ID**

Uniformed Services Identification Card - Active Duty

Uniformed Services Identification Card - Active Duty Family Member



Common Access Card

- **Health Insurance Card**

- **State Corporation Papers**
- **State Tax Papers**

PROMISe™ Provider Enrollment Packet Checklist

The following checklist contains the most common reasons enrollment applications are returned. Please review the checklist for each enrollment application**. Incomplete enrollment packets will result in your application being rejected as of May 1, 2015.**

Did you remember to……

Use the current application found on the DHS website.

Use black ink.

Complete all fields as required on the application with either your correct information or N/A.

Verify you have entered the correct number of digits where specified.

Indicate one or more provider specialty codes. (Boxes 6 and 7)

Enter at least one Provider Eligibility Program (PEP). (Box 23j)

Enter your MPI# and Service Location Code in box 2

Sign and date the provider enrollment application. **Date must** be within 30 days of submission.

Did you remember to attach…….

For individual enrollment, a copy of your Social Security card or W-2. (Box 9)

For agency enrollment, documentation from the IRS for tax identification purposes (a copy of your Federal Tax Identification Number label or document). Remember, a W-9 is not acceptable.

If applicable, Corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.

If applicable, a copy of your:

- Professional License
- Any other certification, license or permit that applies.

Your signed and dated provider agreement

All application pages.