Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
Consolidated Community Reporting Initiative Provider Enrollment Application Short Form

Instructions for Completing the Consolidated Community Reporting Initiative (CCRI) Provider Enrollment Application – Short Form

This application is for providers already enrolled in either Medical Assistance Fee-for-Service or HealthChoices and requesting enrollment as a CCRI provider.

1. **Action Requested:**

   Enter the effective date of enrollment and your 13 digit PROMISe™ provider ID number.

2. **Enrollee's Name:**

   List the applicant's name (individual practitioner or facility) and date of birth (if applicant is an individual). If operating under a fictitious business/doing-business-as (dba) name, attach copy of recorded/stamped fictitious business name statement/permit.

3. **Provider Type Number and Description:**

   Enter the provider type number and the description of the provider type you are requesting enrollment for.

4. **Provider Specialty Number and Description:**

   Enter the provider specialty and the description of the provider specialty you are requesting enrollment for.

5. **License number:**

   Enter the professional or state license number, if applicable

6. **Physical Service Location:**

   List the physical address where services will be provided. A Post Office Box is not a valid service location.

6a. Mail to Information:

Indicate the address where you want correspondence to be mailed. (e.g. notification of enrollment)

7. Sign and date the application, print your name and list your telephone number. The signature should be that of the individual applying for enrollment, or someone able to represent the facility applying for enrollment. Use black ink.

Forward completed application to the county in which the CCRI contract is associated with.

The County MH/MR representative will be required to complete and submit the "CCRI Attestation Form" to support the enrollment of this service provider along with the completed application. The documentation should be sent to:

DHS/OMHSAS
Business Partner Support Unit
Commonwealth Tower 12th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675

or

The application may be sent via email to: RA-PWSERVICES@pa.gov

Updated 07/01/2019

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This application is for providers already enrolled in either Medical Assistance fee-for-service or HealthChoices and requesting enrollment as a CCRI provider.

1. Action Requested: ☒ Add the EPOMS PEP to an existing service location.

   Effective date of enrollment: _____

   PROMISe™ Provider ID & Service Location: ___ ___ ___ ___ ___ ___ ___ ___ ___/___ ___ ___ ___

2. Enter Name of Enrollee:

   Facility Name:

   _____

   Or

   Last Name: _____ First: _____ Middle: _____

   Date of Birth: __ __ __ __/ __ __ /__ __ Ex: (2012/xx/xx) Gender: ☐ Male ☐ Female

3. Provider Type Number and Description: ___ ___ /_____

4. Provider Specialty Number and Description: ___ ___ ___/_____

5. License Number: _____ (Professional or State License, if applicable)

6. Physical Service Location:	6a. Mail to Information:
_____ Street	_____ Street
_____ City _____ State _____ Zip (9 digit)	_____ City _____ State _____ Zip (9 digit)
_____ County	_____ County
(__ __ __) __ __ __-__ __ __ __ Phone	(__ __ __) __ __ __-__ __ __ __ Phone
_____ Email	_____ Email

7. I certify that the information provided in this enrollment package is true to the best of my knowledge.

_____ _____ _(____)_____ _____

Provider's Signature | Printed Name | Telephone | Date

Updated 07/01/2019