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| **PURPOSE:** | *This form should be used by:** *New agencies or individual direct service providers who are registering in the Home and Community Services Information System (HCSIS) for the first time*
* *Existing providers who are requesting a change to their existing HCSIS enrollment profile.*

**NOTE: If you would like to make changes to your information for another program office, please contact the respective program office directly.** |
| **STEP 1:** | **Select a completion method. New and existing providers have the option to print out the form found on the next page and complete it by hand then scan and email it to ODP Enrollment or complete the form electronically and e-mail it to ODP Enrollment.**  |
| **STEP 2:**  | New and existing providers should complete the following sections:1. Provider Information
2. Provider Contact Information
3. Description of Change Requested: If the change you are requesting is not listed, check off the “Other” box and explain the change your are requesting in the area titled “Enter explanation for checked off in the space below it”. If your explanation is very long, the form will expand to 2 pages which is acceptable to ODP.
 |
| **STEP 3:** | This step applies to *new* agencies or *new* individual direct service providers only who are registering in HCSIS for the first time. * Agencies or Individuals who are not doing business as sole proprietorships: A copy of the Determination Letter received from the Internal Revenue Service (IRS) is required as proof of the Federal Employer Identification Number (FEIN).
* Individuals who are doing business as a sole proprietorship: A copy of the social security card is required as proof of the Social Security Number (SSN).
* For providers who have multiple locations, please attach additional sheets as necessary.
 |
| **STEP 4:**  | **To email the completed form, enter “HCSIS Verification Request” in the subject line and use the ODP Enrollment e-mail address:** **ra-odpproviderenroll@pa.gov****.**Please allow at least two weeks for the request to be completed. Once completed, an e-mail will be sent from ODP to the provider’s contact e-mail address that was entered on the form by the provider. |

**HCSIS verification Change Request Form**

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| **Provider Information** |

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| --- | --- | --- | --- | --- |
| **Date:** | [ENTER DATE] |  | **Provider Name:** | [ENTER PROVIDER NAME FOUND IN HCSIS] |

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| --- | --- | --- | --- | --- |
| **MPI Number:** | [ENTER 9-DIGIT MPI #] |  | **4-Digit Service Location Code:** | [ENTER 4-DIGIT SERVICE LOCATION CODE] |

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| **Provider Contact Information** |

|  |  |
| --- | --- |
| [ENTER FIRST NAME] | [ENTER LAST NAME] |
| **First Name** | **Last Name** |

|  |  |
| --- | --- |
| [ENTER PHONE # INCLUDING AREA CODE] | [ENTER E-MAIL ADDRESS] |
| **Telephone Number** | **E-mail Address** |

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| **Description of Change Requested – Check all applicable reasons & explain in space below** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Add Site Location | [x]  | Add Provider Type | [ ]  | Add Specialty | [ ]  |
| Delete Site Location |[x]  Delete Provider Type | [ ]  | Delete Specialty | [ ]  |
| A service location that is already enrolled under another program office starts offering ID services | [ ]  |
| Relocation of a provider's business/mailing/payment address | [ ]  | Other | [ ]  |

***Enter an explanation in the space below for the items checked off above*** Helpdesk:

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| **FOR INTERNAL USE ONLY** |

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| --- | --- | --- |
| [ENTER DATE RECEIVED] | [ENTER DATE COMPLETED] | [ENTER WHO COMPLETED] |
| **Date Received** | **Date Completed** | **Completed by** |

If you have questions regarding HCSIS Verification,

e-mail ODP Provider Enrollment unit at ra-odpproviderenroll@pa.gov.