



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services
Division of Developmental Disabilities

NEWSLETTER

Volume 31 No. 23

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TO: Division of Developmental Disabilities (DDD) Providers – **For Action**
Managed Care Organizations – **For Information Only**

SUBJECT: **Provider Enrollment Requirements for Address Changes**

EFFECTIVE: **Immediately**

PURPOSE: To notify Medicaid/NJ FamilyCare Fee-for-Service (FFS) providers regarding provider application requirements for providers changing primary and/or secondary location addresses.

BACKGROUND: The New Jersey Division of Medical Assistance (DMAHS) and the New Jersey Division of Developmental Disabilities (DDD) have received inquiries regarding provider application requirements for a provider changing to a new provider address.

ACTION: **Effective immediately**, Gainwell Technologies, the State’s Fiscal Agent, is changing the DDD Supports Program and Community Care Program (CCP) provider application to:

- (1) allow providers to indicate when their application is being submitted for a change in a provider’s primary location; and
- (2) report a change in a provider’s secondary location. **Providers must continue to submit fully completed applications.**

When changing a provider’s primary location, the provider must respond “Yes” to the question: **“Is this a change in the primary physical location?”** found in the “Primary Physical Location” section of the application. For a secondary location address change, only the **“Secondary Location Change”** section needs to be completed. This new section (see below) requests information related to the secondary location address change. When there is a secondary location address change, **the provider is not required to report information related to all other secondary locations in their provider network.** Payment of an application fee is not a requirement for DDD providers.

18. Secondary Location Change

A. Name: _____

1). Prior Address:

Street: _____

City: _____

State: _____ Zip: _____ County: _____

2) New Address:

Street: _____

City: _____

State: _____ Zip: _____ County: _____

Existing Medicaid Provider # (if you have one): _____ NPI # (if different) _____

3). List the name, birth date, social security #s of, agent(s), administrator(s) and managing employees:
(use separate sheet of paper if needed)

a. _____

b. _____

c. _____

d. _____

If you have any questions concerning this Newsletter, please contact the Gainwell Technologies Provider Enrollment Unit at (609) 588-6036.

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