

Attachment #1: New Provider Qualification Approval Template

Provider Name: Provider Name

Dear: Provider Qualification Primary Contact Name,

Attached is your DP 1059, which verifies your qualification for specific services through the Consolidated, Community Living and Person/Family Directed Support (P/FDS) Waivers.

Your next step is to complete a PROMISE enrollment application using the MA Program On-line Provider Enrollment Application System. You are required to attach your approved DP 1059 along with all other required supporting documentation.

You can resubmit qualification documentation for any specialty for which you have been determined “not qualified” one additional time within a 365 day period. Your original qualification application date for Specialty Name(s) was ___ [date of this letter]___ with an ending date of _____ for the 365-day period.

If the DP 1059 indicates you are not qualified to provide specific services through the Consolidated, Community Living and Person/Family Directed Support (P/FDS) Waivers, you may appeal this decision by filing a request for hearing in writing within thirty-three

(33) days of this letter to:

Department of Human Services

Bureau of Hearings and Appeals

2330 Vartan Way Second Floor

Harrisburg, PA 17110-9721

A copy of your appeal must be sent to:

Department of Human Services

Office of Developmental Programs

Division of Program Management

P.O. Box 2675

Harrisburg, Pennsylvania 17105

Please refer to 55 Pa. Code Chapter 41 (relating to Medical Assistance Provider Appeal Procedures) for more information about your appeal rights and responsibilities. You may view Chapter 41 in its entirety at: [MA Provider Appeal Procedures](#)

If you have any questions, please do not hesitate to contact me at [PQ AE Lead Contact Information](#).

Thank you.

Name of PQ AE Lead

cc: Regional PQ Lead