Return this completed enrollment packet to:
EDS Provider Enrollment
PO Box 909
New Castle DE 19720

Do not write here
Enrollment Tracking #
Sanction DUPL EDS
Entered: Effective:
Provider #
New ReEn Tax ID/SSN
PPI
Ind CLIA DEA
Medicare Email Net / Paper

Delaware Medical Assistance & Diamond State Partners
Provider Enrollment Packet
Individual

Welcome to the Delaware Medical Assistance Program. This enrollment packet has been prepared for use by individual providers. This packet is divided into five parts: 1. Individual Provider Application, 2. Additional Documentation (these forms are included in this packet), 3. Electronic Funds Transfer (EFT) 4. Attachments (the provider **must** include copies), 5. Diamond State Partners Form.

To complete the application process, you will need the following documents. Except for the attachments, all of these documents are included in this enrollment packet. See the instructions in Part 4 for information on attachments.

_____ **Individual Provider Application – (Required)**

_____ ***Two*** **Copies of the Provider Contracts – (Required)**

_____ **W-9 Form – (Required)**

_____ **Electronic Funds Transfer Form** (optional)

_____ **Electronic Claims Submission Form** (optional)

_____ **Authorized Signer Form (optional)**

_____ **Attachments** (listed in instructions for Part 4)

_____ **Diamond State Partners Form** (optional)

Before you begin filling out this enrollment packet, first complete the W-9 form that is included at the end of the packet. This is a two-page form that includes directions for completion. It must be signed and dated by the provider. You will use the name, address, and social security number (Tax ID numbers are **only** used if you are a sole proprietor) entered on the W-9 to complete this application.

Once you have assembled and completed all of the required materials, take a moment to check off each of the pieces listed above. Incomplete applications are returned to the provider. Please make sure that you have remembered to **sign and date** all forms.

Make a copy of this enrollment packet for your records. Send the original to EDS to the address at the top of this page. If you have questions about completing this application, or about the status of your application, call EDS Provider Relations at: (302) 454-7154 or 1-800-999-3371.

NOTE: Individual providers already enrolled as a Delaware Medical Assistance Provider do not need to re-enroll if they are simply joining a different group.

NOTE: Group providers should use the Group Enrollment Packet. Request a packet from EDS Provider Relations and specify that you need a Group Enrollment Packet.

NOTE: Do **not** include claims with this enrollment packet. They will be returned.

Part 1: Individual Provider Application

1. **Provider name and primary service location:** This name is also entered on the Provider Contracts attached to this enrollment packet. The address is the physical address of the individual. While you may include a post office box, you **must** use a street address. If you have additional service locations, enter them on page 6, field 23, Additional Addresses.

Name _____

Credential (DO, MD etc.)_____

Primary Service Location

Street Address _____

P.O. Box _____

City _____ **State** _____ **Zip** _____

Phone (____) _____

Please give us the following information regarding this enrollment application:

Contact Name _____

Phone Number_____Fax Number_____

2. **Participation:** Have you been a Delaware Medical Assistance provider at any time in the past? **YES NO**

3. **Centers for Medicare & Medicaid Services (CMS):** Have you ever been sanctioned by CMS or had your license revoked? If yes explain on a separate piece of paper. **YES NO**

4. **Language -** What primary language do you speak, leave blank if English is primary language. _____

5. **Obstetrics** – Do you provide medical obstetric care? **YES NO**

6. **Delivery Privilege** – Do you have hospital delivery privileges? **YES NO**

7. **Hours** – What is the total number of office hours per week? _____

8. **Hospital Privilege** – Do you have hospital admitting privileges? **YES NO**

9. **Handicap Accessible** – Is your primary business service location handicap accessible? **YES NO**

10. **Board certified:** Are you board certified? **N/A YES NO**

11. **Business Type** - circle one **Individual Sole Proprietor**

12. **Taxonomy (10 digit – list attached page 5)**

13. **Fiscal Year End** – Month

14. **Social Security Number:** This must match the number on the W-9 form. Only sole proprietors can enter a Tax ID number.

15. **Medicare number:** Enter your Medicare provider number here. This field is necessary for claims to crossover electronically from Medicare to Delaware Medical Assistance.

16. **State License Number:** Current copy must be attached.

Number:

Effective Date:

End Date:

17. **Clinical Laboratory Improvement Amendments (CLIA):** If used, enter the number from your CLIA certificate, the effective and end dates and the certificate type, this field is optional.

CLIA Number:

Effective Date:

End Date:

Certificate Type:

18. **DEA Number:** Enter the number on your DEA certificate, the start date and end dates, and attach a copy of the certificate to this application.

DEA Number:

Effective Date:

End Date:

19. **Effective Date:** Sometimes services are rendered to a client before the person or business has enrolled with the Delaware Medical Assistance Program as a provider. When this happens, the provider can request that the effective date or enrollment be backdated. The requested effective date must be covered by any applicable license or certification submitted with this application. Enter the requested effective date for your enrollment as a Medical Assistance Provider.

Note: Timely filing requirements are 365 days from date of service.

20. **Remittance Advice:** when you begin to bill the Delaware Medical Assistance Program for claims, you will receive a remittance advice (RA) every week that you have claim activity in the system. The RA explains the status of your claim. A pended claim is a claim that has not been paid or denied but is being held for further review. Select YES if you want to be informed of the status of pended claims. Do you want pended claims information on your RA?

YES NO

21. **Electronic Remittance Advice:** You now have the option to receive your weekly remittance advice electronically by accessing a "Bulletin Board". The Bulletin Board can be accessed through our Provider Electronic Software or your vendor software.

YES NO

Do you want to receive your remittance advice electronically?

22. Medical Assistance Program Participation: Place an "X" next to the programs you will be participating with in Delaware.

____ Delaware Medical Assistance Program

____ Part C – Birth to Three

____ Delaware Prescription Assistance Program (DPAP)

____ Dental

____ Chronic Renal Disease Program

____ Early Periodic Screening and Development Treatment (EPSDT)

____ Diamond State Partners Program (Please complete section 5 of this application)

____ All Programs, except Dental & DPAP

____ All Programs

Providers may disenroll at any time by giving us written notice to the address on the front page of this application.

23. Taxonomy

Refer to the list of specialties given below and check the provider specialty that best describes your individual specialty. You may have more than one specialty.

NOTE: individual providers who are affiliated with a multi-specialty group should enroll under their own individual specialty.

Select	Taxonomy Code		Select	Taxonomy Code	
		Certified Registered Nurse			**Dentist**
	363L00000X	Certified Registered Nurse Practitioner		122300000X	Dentist
	364SS0000X	Clinical Nurse Specialist			
		EPSDT – CSCRP Services			**Nurse Midwife**
	323P00000X	Psychiatric Residential Treatment Center		367A00000X	Nurse Midwife
	261QH0801X	Outpatient Adolescent Psychiatric			
	103TC1900X	Psychological Counseling Services			
	261QH0100X	Clinic/Center, Health			**Optometrist/ Optician**
	235Z00000X	Speech-language pathologist (Speech/Language/Hearing Services)		332H00000X	Optician
	225X00000X	Occupational Therapist		152W00000X	Optometrist
	225100000X	Physical Therapist			**Private Duty Nurse**
	133NN1002X	Dietician Services		164W00000X	Private Duty Nursing - LPN
	163W00000X	Registered Nurse (Nursing Services)		163W00000X	Private Duty Nursing – RN
		Physician			**Physician Con't**
	207BA0200X	Allergy		207W00000X	Ophthalmology/Otolaryngolo
	207L00000X	Anesthesiology		1223P1006X	Oral Pathology
	207RC0000X	Cardiology		207Y00000X	Otolaryngology

Select	Taxonomy Code		Select	Taxonomy Code	
	207N00000X	Dermatology		207ZP0101X	Pathology
	207RE0101X	Endocrinology		208000000X	Pediatrics
	207RG0100X	Gastroenterology		208100000X	Physical Medicine / Rehab
	207Q00000X	General / Family Practice		2084P0800X	Psychiatry
	207QG0300X	Gerontology		207RP1001X	Pulmonary Disease
	207V00000X	Gynecology / Obstetrics		2085R0203X	Radiation Therapy
	207RH0003X	Hematology		2085R0202X	Radiology
	207P00000X	Hosp. Based Emerg Physician		207RR0500X	Rheumatology
	207R10200X	Infectious Disease		208BS0129X	Surgery / Cardiology
	207R00000X	Internal Medicine		208C00000X	Surgery / Colon-Rectal
	2080N0001X	Neonatology		208600000X	Surgery / General
	207RN0300X	Nephrology		207T00000X	Surgery / Neurological
	2084N0400X	Neurology		1223S0112X	Surgery / Oral
	207U00000X	Nuclear Medicine		207X00000X	Surgery / Orthopedic
	207RX0202X	Oncology		208200000X	Surgery / Plastic
	207W00000X	Ophthalmology		208G00000X	Surgery / Thoracic
		Podiatry		208800000X	Urology
	213E00000X	Podiatry			

DIAMOND STATE PARTNERS

If you are enrolling as one of the provider types listed below , you **must** choose one of the following taxonomies in order to provide a full range of services approved for your provider type under Diamond State PartnersPlease choose a taxonomy that represents your specialty for Diamond State Partners. You may only use this taxonomy to submit claims for Diamond State Partners clients. Claims submitted for DMAP clients using one of the taxonomies below will be denied.

Refer to the list of specialties given below and check the provider specialty that best describes your specialty. You may have more than one specialty.

Select	Taxonomy code		Select	Taxonomy code	
	111NX0800X	Chiropractor		2355S0801X	Speech Therapy
	2251X0800X	Physical Therapy		133NN1002X	Nutrition/Dietician
	225XR0403X	Occupational Therapy		1041C0700X	Behavioral Health Counselor
	101YA0400X	Counselor Addiction		103TR0200X	Psychology
					Other - _____

Additional Addresses

24. Name, address, telephone, and email: providers may have different addresses and telephone numbers for different purposes. The Pay-to name must be the same as the Provider Name used on page 2.

Pay-to (required)
This is the name that will appear on your check and is reported to the IRS. Checks and remittance advice will be mailed to this address. **This is a required field**.

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Remittance Advice Address (optional)
This is the name and address where your weekly remittance advice will be mailed, The Pay-to name and address will be used if this field is left blank.

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Mail-to Address (optional)
This is the name and address where correspondence is mailed, including newsletters and provider handbooks. The Pay-to name and address will be used if the Mail-to address is left blank. This is an optional field.

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Contact Address (optional)
This is the name and address used for the specific person to be contacted for questions about claims if it is different from the provider. This is an optional field.

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Billing service address (optional)
This is the name and address that is used if a billing service handles your claims. This is an optional field.

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

This is the name and address of additional service locations that the provider will use to provide services. While you may include a post office box, you **must** use a street address.

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Name
Street address
P.O. Box
City State Zip
Phone ( )
Fax ( )
Email

Individual Affiliation Roster

25. This **roster** is used by individual providers who wish to affiliate with a group (or groups) already enrolled in the Delaware Medical Assistance Program.

Do **not** complete this page if you are an individual provider and are not affiliated with a group practice.

NOTE: Listing a group on this form does **not** enroll the group in the Delaware Medical Assistance Program. A group application must be submitted for the group practice.

NOTE: The individual provider must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name	Delaware Medical Assistance Group Provider Number	Date Effective With Group	Taxonomy 10 Digits

I wish to be affiliated with the above listed groups in the Delaware Medical Assistance Program.

Signature: _____

Name typed or printed: _____

Date: _____

I hereby Certify that I have examined this application and that the representations that are contained in this application are true and correct and agree to notify the Medical Assistance Program, in writing, of any changes to this application.

_____ _____

Signature **Date**

Authorized Signer Form

I hereby appoint as my agent the following persons and authorize them to submit and sign claims on my behalf to the State of Delaware Medical Assistance Program (which includes all programs as listed in Item 21, "Medical Assistance Program Participation") in my capacity as a Medical Assistance Provider. I hereby agree to notify the State of Delaware in writing and submit a signature sample if there are any changes in the below stated individuals. Add extra sheets as necessary.

_____ _____

Signature of Provider Date

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

Part 2 – Additional Documentation

Included in this enrollment packet are five additional documents. To complete this application you must:

A. Complete the two-page **W-9 Form** found at the back of this packet. Follow the instructions on the form. The name on the W-9 must be the same name used for the 'Pay to" address on page 6 of the application. The W-9 must also contain your social security number (only sole proprietors can use Tax ID numbers). Date and sign the form. This form is **required**.

B. Read, sign, and date the **Provider Contracts**. Enter the same name for the provider as you entered for the Provider Name and Primary Service Location on page 2 of the application. The person enrolling as an **individual** provider must sign and date this agreement. No other person can be authorized to sign for an individual provider. ***Two*** complete forms are **required**.

C. When submitting paper claims, providers **must** sign **every** claim form. The individual signing the claim must be an authorized signer and the authorized signer form must be in your file with us. This form is **not required** if the individual doctor/provider is signing each claim form**.**

D. Complete the **Authorization of Electronic Funds Transfer** form if you choose to have your payments automatically deposited to your banking account. This form is **optional**.

E. Complete the Electronic Claims Submission Provider Certification form if you choose to bill electronically. This form is **optional**. The form can be downloaded from the DMAP Web site at http://www.dmap.state.de.us. Select the Downloads tab, and Forms.

Part 3 – Authorization for Electronic Funds Transfer

If you choose to have your payments automatically deposited into your bank account, please complete all the sections below. The transaction routing number can be obtained from your bank. Attach a voided check.

Provider Name	
Bank Name	**Bank Phone Number**
Bank Address	
Account Number	
Transaction Routing Number (nine digit) __ __ __ __ __ __ __ __ __	
Type of Account (circle only one) **Checking** **Savings**	

I hereby authorize EDS to present credit and/or debit entries into the financial account referenced above and the depository named above to credit and/ or debit the same to such account. I understand that I am responsible for the validity of the information on this form. If the funds are erroneously deposited into my account, I authorize EDS to initiate the necessary debit entries, not to exceed the total of the original amount of the deposit in error.

Authorized Signature _____ Date _____

Name typed or printed: _____

Attach a voided check here.

Voided check is **Required**.

Part 4 – Attachments

Providers are required to include copies of the following documentation unless otherwise noted. It is the provider's responsibility to have valid documentation for all dates of service. **Do not send original documents**.

NOTE: do **not** include claims with this enrollment packet. They will be returned.

Medical License
All individual providers are **required** to include a copy of their current license issued by their state's Board of Professional Licensing. All out-of-state providers enrolling with the Delaware Medical Assistance Program must meet the licensing requirements of the state in which they are located. The name on the license must match the name of the enrolling provider.

It is the provider's responsibility to have a valid license for all dates of service. Do not send original documents, they will not be returned.

CLIA Certification
If field 17 in Part 1 is completed, a copy of CLIA certification is required. The dates on the CLIA certification must cover the effective date for enrollment.

DEA Certification
If field 18 in Part 1 is completed, a copy of current DEA certification is required.

DIAMOND STATE PARTNERS

Additional Questions for Diamond State Partners Application:

Please note answers for each location where services will be provided.

Photocopy this page for any/all additional sites.

The provider is required to notify Diamond State Partners of any changes to these services or limitations herein described in the application.

- **Patients:** What is the maximum number of Diamond State Partners patients accepted? _____

- **Practice Restrictions -** Are patients of all ages accepted? **YES** **NO**

  If no, what is the:

  - **Minimum Age:** What is the minimum age of patients accepted? _____
  - **Maximum Age:** What is the maximum age of patients accepted? _____

- **Gender -** Is your practice limited to:

  Male only **Female only** **Both Male & Female**

- **Patient Admittance -** Is your practice open to:

  - Current Patients Only **YES** **NO**
  - Current & New Patients **YES** **NO**

Service Location Address: _____
_____

All documentation should be submitted to:

EDS Provider Enrollment

PO Box 909

New Castle, DE 19720

Any questions please contact EDS Provider Relations at:

302-454-7154 or 1-800-999-3371