

Return this completed enrollment packet to:  
HP Enterprise Services, LLC  
Provider Enrollment  
PO Box 909  
New Castle DE 19720

**Do not write here**

**Enrollment Tracking #**

Sanction	DUPL	HP		
Entered:		Effective:		
Provider #				
New	ReEn	Tax ID/SSN		
PPI				
Ind	CLIA	DEA		
Medicare			Email	Net / Paper

**Delaware Medical Assistance Provider Enrollment Packet  
Hospital**

Welcome to the Delaware Medical Assistance Program. This enrollment packet has been prepared for use by hospital providers. This packet is divided into four parts: 1. Hospital Provider Application, 2. Additional Documentation (these forms are included in this packet), 3. Electronic Funds Transfer (EFT) 4. Attachments

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.

- \_\_\_\_\_ **Hospital Provider Application – (Required)**
- \_\_\_\_\_ **Two Copies of the Provider Contracts – (Required)**
- \_\_\_\_\_ **Copy of Tax ID Number and/or Social Security Card – (Required)**
- \_\_\_\_\_ **Disclosure of Ownership and Control Interest Statement – (Required)**
- \_\_\_\_\_ **Authorization for Electronic Funds Transfer Form (Optional)**
- \_\_\_\_\_ **Delaware Title XIX Electronic Claim Submission Provider Certification Agreement (Optional)**
- \_\_\_\_\_ **Authorized Signer Form**
- \_\_\_\_\_ **Attachments (listed in instructions for Part 4)**

You will use the name associated with your Social Security Card and/or Tax ID number to complete this application.

A copy of your Tax ID Number and/or Social Security Card must be attached. Any Social Security cards that state, “valid for work only with INS authorization”, or “valid for work only with DHS authorization” must also include the Form I-9 titled Employment Eligibility Verification OR any of the non-expired Department of Homeland Security-acceptable employment authorization documents as listed on page 5 of the Employment Eligibility Verification Form. Any Social Security card that states “not valid for employment” will not be accepted. 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 HP Enterprise Services, LLC 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 HP Enterprise Services, LLC Provider Relations at: 1-800-999-3371.

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

## Part 1: Hospital Provider Application

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

**Name** \_\_\_\_\_

**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 \_\_\_\_\_

Email Address \_\_\_\_\_

2. **Participation:** Has your hospital ever been a Delaware Medical Assistance provider at any time in the past? **YES NO**

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

4. **Hours** -- What is the total number of office hours per week? \_\_\_\_\_

5. **Handicap Accessible** – Is the hospital handicap accessible? **YES NO**

6. **Business Type** - circle one

Government Owned  
 Business Corp. for profit  
 Business Corp. non-profit  
 Private – for profit  
 Private – non-profit  
 Partnership  
 Trust

7. **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:** \_\_\_\_\_

**8. License:** Current copy must be attached

**Number:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**End Date:** \_\_\_\_\_

**9. Fiscal Year End – Month**

**10. Tax ID Number:** Must attach a copy of your tax ID number and/or a copy of your Social Security card. A copy of your Tax ID Number and/or Social Security Card must be attached. Any Social Security cards that state, “valid for work only with INS authorization”, or “valid for work only with DHS authorization” must also include the Form I-9 titled Employment Eligibility Verification OR any of the non-expired Department of Homeland Security-acceptable employment authorization documents as listed on page 5 of the Employment Eligibility Verification Form. Any Social Security card that states “not valid for employment” will not be accepted.

**11. National Provider Identifier (NPI):**

**12. 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. Enter the requested effective date for your enrollment as a Medical Assistance Provider.

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

**13. Pended Claims Status on Remittance Advice:** You will receive a remittance advice (RA) every week that you have claim activity in the system. The RA explains the status of your claims. A pended claim is a claim that has not been paid or denied but is being held for further review. Do you want pended claims information on your RA?”

YES NO

**14. Electronic Remittance Advice:** You 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. Do you want to receive your remittance advice electronically?

YES NO

**15. Inspection Date:** What is the date your facility was last inspected?

What is the date of your next inspection?

**16. Beds:** Complete the following table

	<b>Licensed Bed Capacity</b>
<b>Medicaid Beds</b>	
<b>Medicare Beds</b>	
<b>Swing Beds</b>	

**17. Taxonomy**

Refer to the list of specialties given below and check all that apply.

<b>Select</b>	<b>Taxonomy code</b>	
	282N00000X	Acute Care Inpatient/Outpatient Hospital
	283X00000X	Rehabilitation Inpatient Hospital
	284300000X	Specialty Inpatient Hospital
	273Y00000X	Certified Physical Rehab Wing of Acute Care Hospital
	283Q00000X	Inpatient/Residential Behavioral Health Facility

## Additional Addresses

**18. 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 \_\_\_\_\_

### Service Location Address (optional)

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 \_\_\_\_\_

### Service Location Address (optional)

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

### Service Location Address (optional)

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



## Part 2 – Additional Documentation

---

Included in this enrollment packet are additional documents. An original signature is required on all documents. To complete this application you must:

- A. 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 of the application. The person signing this enrollment application must sign and date the contracts. No other person can be authorized to sign for the facility. **Two** complete forms are **required**.
- B. Complete the **Disclosure Statement** form found at the back of this packet. Follow the instructions on the form. This form is **required** by all providers except Division of Public Health and State facilities.
- C. Complete the **Authorized Signer Form** in this packet if anyone other than the individual signing the contracts will be submitting claim forms to the Delaware Medical Assistance Program. 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 signing the contracts is the individual that will be signing every claim form submitted to the Delaware Medical Assistance Program.
- D. Complete the **Authorization of Electronic Funds Transfer** form in this packet if you choose to have your payments automatically deposited to your banking account. This form is **optional**.
- E. Complete the **Delaware Title XIX Electronic Claim Submission Provider Certification Agreement** found at the back of this packet 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, then 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.

<b>Provider Name</b>	
<b>Bank Name</b>	<b>Bank Phone Number</b>
<b>Bank Address</b>	
<b>Account Number</b>	
<b>Transaction Routing Number</b> (nine digit)    _ _ _ _ _ _ _ _ _	
<b>Type of Account</b> (circle only one)	<b>Checking          Savings</b>

I hereby authorize HP Enterprise Services, LLC to present credit and/or debit entries into the financial account referenced above and the depository named above to credit and/ or debits 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 HP Enterprise Services, LLC to initiate the necessary debit entries, not to exceed the total of the original amount of the deposit in error.

I understand that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Name typed or printed: \_\_\_\_\_

**Attach a voided check here.**

Voided check is **Required**.

Part 3 - Electronic Funds Transfer (EFT)

## 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 as they will not be returned.**

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

### A. NPI Assignment Letter

A copy of your NPI letter or copy of electronic verification must be attached.

### B. Hospital License

All hospitals are **required** to supply a copy of a license issued by a State-recognized authority for the state in which they are located with the expiration date. The license must support the category of enrollment requested; e.g. acute care facility or general hospital.

### C. CLIA Certification

If field 7 in Page 2 is completed, a copy of CLIA certification is required. The dates on the CLIA certification must cover the effective date for enrollment.

### D. Tax ID Number and/or Social Security Card

A copy of your Tax ID Number and/or Social Security Card must be attached. Any Social Security cards that state, "valid for work only with INS authorization", or "valid for work only with DHS authorization" must also include the Form I-9 titled Employment Eligibility Verification OR any of the non-expired Department of Homeland Security-acceptable employment authorization documents as listed on page 5 of the Employment Eligibility Verification Form. Any Social Security card that states "not valid for employment" will not be accepted.

All documentation should be submitted to:

**HP Enterprise Services, LLC**

**Provider Enrollment**

**PO Box 909**

**New Castle, DE 19720**

Any questions please contact HP Enterprise Services, LLC Provider Relations at:

**1-800-999-3371**