

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:		
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New	ReEn	Tax ID/SSN		
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Medicare			Email	Net / Paper

**Delaware Medical Assistance Provider Enrollment Packet
MEDICARE PRESCRIPTION DRUG PLAN (PDP)**

Taxonomy: 302F00000X

Welcome to the Delaware Medical Assistance Program. This enrollment packet has been prepared for use by Medicare Prescription Drug Plan providers. This packet is divided into four parts: 1. Medicare Prescription Drug Plan Provider Application, 2. Additional Documentation, - (these forms are included in the packet) 3. Authorization for Electronic Funds Transfer (EFT) 4. Attachments – (the provider **must** include copies)

To complete the application process, you will need the following *required* documents. All of these documents are included in this enrollment packet.

- _____ **Medicare Prescription Drug Plan Provider Application**
- _____ **Copy of Tax ID Number and/or Social Security Card – (Required)**
- _____ **Two Copies of the Medicare Part D PDP Contract**
- _____ **Authorization for Electronic Funds Transfer Form**
- _____ **PDP Certification Agreement for Electronic Premium Payment Transaction**

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.

Part 1: MEDICARE PRESCRIPTION DRUG PLAN (PDP) Provider Application

1. Provider name and location: This name is also entered on the Medicare Part D PDP Contracts attached to this enrollment packet. The address is the physical address of the PDP. 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 section page.

Primary Service Location

Name _____

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. Business Type - circle one

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

3. National Electronic Insurance Code (NEIC) Number:

4. Fiscal Year End:

5. 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.

6. Electronic Remittance Advice: You have the option to receive your monthly 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

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.

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

Additional Addresses

7. 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 **Medicare Part D PDP Contracts**. Enter the same name for the provider as you entered for the Provider Name and Location section of the application. The person signing this enrollment application must sign and date the contracts. **Two** complete forms are **required**.

- B. Complete the **Authorization for Electronic Funds Transfer** form to have your payments automatically deposited to your banking account. Please be advised that there is a testing period that will need to be successfully completed. It is not an immediate process.

- C. Complete the **PDP Certification Agreement for Electronic Premium Payment Transaction**.

Part 3 – Authorization for Electronic Funds Transfer

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 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 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 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.

Voiced check is **Required.**

Part 4 – Attachments

Providers are required to include copies of the following documentation. **Do not send original documents as they will not be returned.**

A. CMS PDP Approval Letter

Providers must also provide documentation of their Part D Plan contractor number if it is not reflected on the CMS PDP Approval Letter.

B. Premium Schedule

C. Organizational Chart

Providers must submit an organizational chart that depicts the national name of the corporation and subsidiaries that may be linked to the PDP.

D. Tax ID Number and/or Social Security Card

Providers must submit a copy of their 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:

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

1-800-999-3371