

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
Transportation**

Welcome to the Delaware Medical Assistance Program (DMAP). This enrollment packet has been prepared for use by Transportation providers. This packet is divided into four parts: 1. Transportation Provider Application, 2. Additional Documentation (these forms are included in this 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 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.

- _____ **Transportation Provider Application – (Required)**
- _____ **Copy of Tax ID Number and/or Social Security Card – (Required)**
- _____ **Two Copies of the Provider Contracts – (Required)**
- _____ **Disclosure of Ownership and Control Interest Statement (Required)**
- _____ **Authorized Signer Form**
- _____ **Authorization for Electronic Funds Transfer Form (Optional)**
- _____ **Delaware Title XIX Electronic Claim Submission Provider Certification Agreement (Optional)**
- _____ **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: Transportation Provider Application

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

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

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**

Language – What primary language do you speak, other than English

5. Business Type - circle one

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

6. Taxonomy (Please check the taxonomy that describes your service.)

Select	Taxonomy code	
<input type="checkbox"/>	3416L0300X	Ground Ambulance
<input type="checkbox"/>	3416A0800X	Air Ambulance

7. **Fiscal Year End** – Month

8. **Social Security or Tax ID Number:** Only sole proprietors can enter a 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.

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

10. **Certificate of Commercial Insurance:** issued by an insurance agency/company.

Insurance Number: _____

Effective Date: _____

End Date: _____

11. **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. We do not suggest that you provide service to a DMAP client before a provider number is assigned. There is no guarantee that you will get paid for the service. 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.

12. **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

13. **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

Additional Addresses

14. 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 on page 2 of the application. The person signing the enrollment application must be the same individual signing the contracts, and they must be the owner or have an interest in the company. **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**.

- C. Complete the **Authorized Signer Form** 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 if you choose to have your payments automatically deposited to your banking account.

- E. Complete the Electronic **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.

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.

Voided check is **Required**.

Part 4 – Attachments

Transportation providers are required to include copies of the following documentation. 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.

NPI Assignment Letter

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

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.

Ambulance - Ground

Ambulance Certification

The Ambulance Certification is issued by the State of Delaware Fire Prevention Commission. If a provider is located in a state other than Delaware, a certification issued by a comparable certifying agent is required.

- The certification must not be expired. If the certification is due to expire during the month that the provider's application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new certification.

Ambulance Attendant Certification List

This List is issued by the State of Delaware, the State Fire Prevention Commission, or a comparable agency for applicants located in a state other than Delaware.

- The list must name all attendants employed by the ambulance company with the expiration date of each attendant.
- The certification must not be expired. If the certification is due to expire during the month that the provider's application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new certification.

Ambulance Attendant Certification Card

This Certification card is issued by the State of Delaware, the State Fire Prevention Commission, or a comparable agency for applicants located in a state other than Delaware.

- A copy of a certification card for each attendant appearing on the certification list must be submitted.
- The certification card must not be expired. If the certification card is due to expire during the month that the provider's application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new certification card.

Ambulance Vehicle Certificate of Insurance

This certification is issued by an insurance agency or insurance company.

The insurance coverage period must not be expired. If the insurance coverage period is due to expire during the month that the provider's application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new certification.

Motor Vehicle Registration Card

This Card is issued by the State of Delaware (or the state in which the provider is located), Division of Motor Vehicle.

- This registration card must not be expired. If the card is due to expire during the month that the provider's application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new registration card.

Ambulance – Air

Certificate to Operate an Air Ambulance Service in Delaware issued by Delaware Office of Emergency Medical Services, Delaware Health and Social Services, Division of Public Health or a certification issued by a comparable certifying agency for applicants located in a state other than Delaware.

- The certification must not be expired. If the certification will expire during the month that the application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new certification.
- The certification must be signed by the Director, Division of Public Health **and** the Director, Office of EMS

Certificate of Aircraft Registration issued by U.S. Department of Transportation, Federal Aviation Administration.

- The certification must not be expired. If the certification will expire during the month that the application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new certification.
- The certification shall include nationality and registration marks, aircraft serial number as well as date of issue and Administrator's signature.

Certificate of Insurance

- The policy must not be expired. If the policy will expire during the month that the application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new policy.
- The policy shall include certificate date, certificate number, certificate holder, policyholder, policy type, insurance company name, policy number and policy period.

Registered Nurse License issued by the State of Delaware, Division of Professional Regulation or a license issued by a comparable certifying agency for applicants located in a state other than Delaware (if applicable).

- The license must not be expired. If the license will expire during the month that the application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new license.

Delaware Emergency Medical Technician License issued by American Heart Association or a license issued by a comparable certifying agency for applicants located in a state other than Delaware.

Certificate issued to RNs by American Heart Association for Basic Life Support (BLS) or a certificate issued by a comparable certifying agency for applicants located in a state other than Delaware Health & Social Services (if applicable).

Delaware Emergency Medical Technician License issued by American Heart Association or a license issued by a comparable certifying agency for applicants located in a state other than Delaware.

- The license must not be expired. If the license will expire during the month that the application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new license.
- The license shall include an ID#, expiration date and classification.

Paramedic License issued by State of Delaware, Division of Professional Regulations or a certificate issued by a comparable certifying agency for applicants located in a state other than Delaware.

- The license must not be expired. If the license will expire during the month that the application is being processed, HP Enterprise Services, LLC will contact the provider to fax a copy of the new license.

List of Usual and Customary Rates

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