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

TO BECOME A DELAWARE MEDICARE CROSSOVER PROVIDER YOU MUST FIRST PROVIDE A SERVICE TO A DELAWARE MEDICAID CLIENT

Delaware Medical Assistance Provider Enrollment Packet
Medicare Individual Crossover

Welcome to the Delaware Medical Assistance Program. This enrollment packet has been prepared for use by Medicare Crossover providers. Medicare Crossover providers can only bill the Delaware Medical Assistance Program after Medicare has made a payment. You will bill the Delaware Medical Assistance Program for the coinsurance and deductible only. This packet is divided into four parts: 1. Medicare Individual Crossover Provider Application, 2. Additional Documentation (these forms are included in this packet), 3. Authorization for Electronic Funds Transfer (EFT) 4. Attachments.

To complete the application process, you will need the following documents. All of these documents are included in this enrollment packet besides the attachments in part 4.

Medicare Individual Crossover 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)**

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: (302) 454-7154 or 1-800-999-3371. Providers may disenroll at any time by giving written notice to the address above.

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

Part 1: Medicare Crossover 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 group. While you may include a post office box, you **must** use a street address. If you have additional service locations, enter them on page 5, field 14, Additional Addresses.

Name ____

Credential (CRNA, Physician Assistant 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_________________

Email Address ____

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

3. **Centers for Medicare & Medicaid Services (CMS):** Have you or your group 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 your primary business service location handicap accessible? **YES NO**

6. **Business Type** - circle one

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

7. **Taxonomy (10 digit – list attached page 4)** ____________________

8. **Fiscal Year End** – Month ____________________

Part 1 – Crossover Application

9. Tax ID or Social Security Number: Must attach a copy of your tax ID number and/or a copy of your Social Security card. (Psychologists, Licensed Clinical Social Workers, Certified Registered Nurse Anesthetists, and Physician Assistants must enroll under their SSN only if they are part of a group.) 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.

10. National Provider Identifier (NPI):

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

Note: timely filing requirements are 6 months from the Medicare paid date.

12. 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

13. 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?

Part 1 - Crossover Application

14. Taxonomy

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

Select	Taxonomy code		Select	Taxonomy code	
	335V00000X	Portable X-Ray Equipment		332S00000X	Hearing Aid Dealer
	111N00000X	Chiropractor		367500000X	Certified Registered Nurse Anesthetist
	103T00000X	Psychologist		363A00000X	Physician Assistant
	231H00000X	Audiology			
	101Y00000X	Licensed Clinical Social Worker			

Individual Affiliation Roster

15. 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.

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.

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

Note: Physician Assistants and Certified Registered Nurse Anesthetists may be affiliated with a participating practitioner group but will be paid for crossover services only.

Note: Psychologists and Licensed clinical social Workers may be affiliated with a participating crossover only psychotherapy group and will be paid for crossover services only.

Group Name	Group NPI 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**

Additional Addresses

16. 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 ______________________

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 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: ____

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 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**.

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** on page 11 of 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 on page13of this packet if you choose to have your payments automatically deposited to your banking account. This form is **optional**.

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 3 - EFT

Part 4 – Attachments

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

B. Medicare Participation Letter
A copy of your Medicare participation letter must be attached.

C. 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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PO Box 909

New Castle, DE 19720

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

1-800-999-3371