

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  
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. Authorization for Electronic Funds Transfer (EFT) 4. Attachments (the provider **must** include copies), 5. Diamond State Partners Application.

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.

- \_\_\_\_\_ **Individual 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)**
- \_\_\_\_\_ **Diamond State Partners Application (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:** 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 HP Enterprise Services, LLC Provider Relations and specify that you need a Group Enrollment Packet.

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

**NOTE:** Providers may disenroll at any time by giving written notice to the address on this page.

## 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 the Additional Addresses page.

	<b>Name</b> _____
	<b>Credential</b> (DO, MD etc.) _____
<b>Primary Service Location</b>	<b>Street Address</b> _____
	<b>P.O. Box</b> _____
	<b>City</b> _____ <b>State</b> ____ <b>Zip</b> _____
	<b>Phone</b> (____) _____

Please give us the following information regarding this enrollment application:

Contact Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

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

- |  |            |               |
|--|------------|---------------|
| 2. <b>Participation:</b> Have you been a Delaware Medical Assistance provider at any time in the past?   | <b>YES</b> | <b>NO</b>     |
| 3. <b>Centers for Medicare &amp; Medicaid Services (CMS):</b> Have you ever been sanctioned by CMS or had your license revoked? If yes explain on a separate piece of paper. | <b>YES</b> | <b>NO</b>     |
| 4. <b>Language:</b> What primary language do you speak? Leave blank if English is primary language.  | _____      |               |
| 5. <b>Obstetrics:</b> Do you provide medical obstetric care?   | <b>YES</b> | <b>NO</b>     |
| 6. <b>Delivery Privilege:</b> Do you have hospital delivery privileges?  | <b>YES</b> | <b>NO</b>     |
| 7. <b>Hours:</b> What is the total number of office hours per week?  | _____      |               |
| 8. <b>Hospital Privileges:</b> Do you have hospital admitting privileges?  | <b>YES</b> | <b>NO</b>     |
| 9. <b>Handicap Accessible:</b> Is your primary business service location handicap accessible?  | <b>YES</b> | <b>NO</b>     |
| 10. <b>Board certified:</b> Are you board certified?   | <b>N/A</b> | <b>YES NO</b> |

11. **Business Type:** Circle one

Individual

Sole Proprietor

12. **Fiscal Year End:** Month

13. **Social Security 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.

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

15. **State License Number:** License must not be expired or expire in the month of enrollment.

License Number: \_\_\_\_\_

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

End Date \_\_\_\_\_

16. **Clinical Laboratory Improvement Amendments (CLIA):** Enter the number from your CLIA certificate, the effective and end dates, and the certificate type. This information is required if you intend to bill laboratory procedures subject to CLIA edits.

CLIA Number: \_\_\_\_\_

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

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

Certificate Type: \_\_\_\_\_

17. **DEA Number:** Enter the number on your DEA certificate, the start date and end dates.

DEA Number: \_\_\_\_\_

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

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

18. **Effective Date:** If services have already been rendered to a Medicaid client, the provider can request that the effective date of enrollment be back dated. 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.

**19. 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

**20. 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

**21. 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 with approval from Part C
- Dental
- EPSDT – only applies to EPSDT-CSCRTP Taxonomies
- Diamond State Partners Program (Please complete Part 5 of this application.)

**22. Taxonomy**

Refer to the list of taxonomies on the following pages and check the taxonomy that best describes your practice. **NOTE:** Individual providers who are affiliated with a multi-specialty group should enroll under their own individual taxonomy.

## INDIVIDUAL PRACTITIONERS

### ***Nurse***

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	367A00000X	Nurse Midwife
<input type="checkbox"/>	363L00000X	Certified Registered Nurse Practitioner
<input type="checkbox"/>	364S00000X	Clinical Nurse Specialist

### ***Optometrist/Optician***

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	332H00000X	Optician
<input type="checkbox"/>	152W00000X	Optometrist

### ***Physician***

Select	Taxonomy	Taxonomy Description	Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	207KA0200X	Allergy	<input type="checkbox"/>	207W00000X	Ophthalmology
<input type="checkbox"/>	207L00000X	Anesthesiology	<input type="checkbox"/>	1223P0106X	Oral Pathology
<input type="checkbox"/>	207RC0000X	Cardiology	<input type="checkbox"/>	207Y00000X	Otolaryngology
<input type="checkbox"/>	207N00000X	Dermatology	<input type="checkbox"/>	208VP0000X	Pain Medicine
<input type="checkbox"/>	207RE0101X	Endocrinology	<input type="checkbox"/>	207ZP0101X	Pathology
<input type="checkbox"/>	207Q00000X	Family Practice	<input type="checkbox"/>	208000000X	Pediatrics
<input type="checkbox"/>	207QA0000X	Family Practice, Adolescent	<input type="checkbox"/>	2080A0000X	Pediatrics, Adolescent
<input type="checkbox"/>	207QA0505X	Family Practice, Adult	<input type="checkbox"/>	208100000X	Physical Medicine/Rehab
<input type="checkbox"/>	207RG0100X	Gastroenterology	<input type="checkbox"/>	2084P0800X	Psychiatry
<input type="checkbox"/>	208D00000X	General Practice	<input type="checkbox"/>	207RP1001X	Pulmonary Disease
<input type="checkbox"/>	207QG0300X	Gerontology	<input type="checkbox"/>	2085R0203X	Radiation Therapy
<input type="checkbox"/>	207V00000X	Gynecology/Obstetrics	<input type="checkbox"/>	2085R0202X	Radiology
<input type="checkbox"/>	207RH0003X	Hematology	<input type="checkbox"/>	207RR0500X	Rheumatology
<input type="checkbox"/>	207P00000X	Hospital-Based Emergency Physician	<input type="checkbox"/>	2086S0129X	Surgery/Cardiology
<input type="checkbox"/>	207RI0200X	Infectious Disease	<input type="checkbox"/>	208C00000X	Surgery/Colon-Rectal
<input type="checkbox"/>	207R00000X	Internal Medicine	<input type="checkbox"/>	208600000X	Surgery/General
<input type="checkbox"/>	207RA0000X	Internal Medicine, Adolescent	<input type="checkbox"/>	207T00000X	Surgery/Neurological
<input type="checkbox"/>	207RG0300X	Internal Medicine, Geriatric	<input type="checkbox"/>	1223S0112X	Surgery/Oral
<input type="checkbox"/>	2080N0001X	Neonatology	<input type="checkbox"/>	207X00000X	Surgery/Orthopedic
<input type="checkbox"/>	207RN0300X	Nephrology	<input type="checkbox"/>	208200000X	Surgery/Plastic
<input type="checkbox"/>	2084N0400X	Neurology	<input type="checkbox"/>	208G00000X	Surgery/Thoracic
<input type="checkbox"/>	207U00000X	Nuclear Medicine	<input type="checkbox"/>	208800000X	Urology
<input type="checkbox"/>	207RX0202X	Oncology			

### ***Podiatrist***

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	213E00000X	Podiatrist

## OTHER PROVIDERS

### **CRNA**

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	367H00000X	Independent Certified Registered Nurse Anesthetist

### **Dental**

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	122300000X	Dentist
<input type="checkbox"/>	1223X0400X	Orthodontist

### **EPSDT-CSCR**

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	323P00000X	Inpatient Adolescent Psychiatric Services
<input type="checkbox"/>	261QM0855X	Outpatient Adolescent Psychiatric Services
<input type="checkbox"/>	103TC1900X	Psychological Counseling Services
<input type="checkbox"/>	261QH0100X	School-Based Health Services

### **Private Duty Nurse**

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	164W00000X	Private Duty Nursing - LPN
<input type="checkbox"/>	163W00000X	Private Duty Nursing - RN

### **Therapist**

Select	Taxonomy	Taxonomy Description
<input type="checkbox"/>	225X00000X	Occupational Therapist
<input type="checkbox"/>	225100000X	Physical Therapist
<input type="checkbox"/>	235Z00000X	Speech-Language Pathologist



To enroll to provide services uniquely available under Diamond State Partners, refer to the list of taxonomies given below and check the provider taxonomy that describes your practice.

NOTE: You may only use these taxonomies to submit claims for Diamond State Partners clients. Claims submitted using one of the taxonomies below for clients not enrolled in Diamond State Partners will be denied.

NOTE: As a Diamond State Partner Nutrition/Dietician, taxonomy 133NN1002X, you can not be affiliated with a Delaware Medical Assistance Program (DMAP) group.

Select	Taxonomy	Taxonomy Description
* <input type="checkbox"/>	1041C0700X	Licensed Clinical Social Worker
<input type="checkbox"/>	101YP2500X	Licensed Professional Counselor Mental Health (LPCMH)
<input type="checkbox"/>	133NN1002X	Nutrition/Dietician
* <input type="checkbox"/>	103TB0200X	Psychologist
<input type="checkbox"/>	101YA0400X	Substance Abuse Counselor

\*Note: Providers, who render services to clients with Medicare, must also complete an Individual Crossover Provider Application.

## Additional Addresses

**23. 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 \_\_\_\_\_

**Individual Affiliation Roster**

**24.** 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.

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



## 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 in Part 1 of this 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** 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 of 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.
- F. Complete the **Diamond State Partners Application** of this packet if you are enrolling as one of the Diamond State Partners taxonomies.
- G. **Dentists, Oral Surgeons, and Orthodontists:** An **Anesthesia Permit** issued by the Division of Professional Regulation is required in addition to a dental license for any dental providers who administer anesthesia. The provider must submit separate permits for each office location and for each individual dental provider administering anesthesia.
- H. **Dental Anesthesiologists:** All anesthesiologists who are employed/contracted for the sole purpose of providing anesthesia for dental/medical related procedures must be enrolled as an individual provider using taxonomy, 207L00000X Anesthesiology. The individual provider must submit a copy of their board certification for anesthesiologists (American Board of Anesthesiology).

### 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</b>	<b>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 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 law.

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

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

**Attach a voided check here.**

Voided check is **Required**.

Part 3 - Authorization for 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. Professional 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..

**C. CLIA Certification**

If number 16 in Part 1 is completed, a copy of the CLIA certification is required. The dates on the CLIA certification must cover the effective date for enrollment.

**D. DEA Certification**

If number 17 in Part 1 is completed, a copy of the current DEA certification is required.

**E. 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.

### Provider Specific Attachments:

**A. Certified Registered Nurse Practitioner:** An **Advanced Practice Nurse License** is required in addition to a Registered Nurse license.

**B. Clinical Nurse Specialist:** An **Advanced Practice Nurse License** is required in addition to a Registered Nurse license.

**C. Independent Certified Registered Nurse Anesthetist:** A list of anesthesia procedure codes (00100-01999) for the services provided is required in addition to a professional license.

**D. Nurse Midwife:** An **Advanced Practice Nurse License** is required in addition to a Registered Nurse license.

**E. Certified Registered Nurse Practitioner, Clinical Nurse Specialist, or Nurse Midwife** who is enrolling as an individual and who will not be affiliated with an enrolled practitioner group must provide the following documentation:

- A copy of a collaborative agreement between the nurse and a licensed physician, dentist, podiatrist, or licensed Delaware health care delivery system to cooperate, coordinate and consult with each other in the provision of health care to their patients. OR
- A copy of a decision of the Joint Practice Committee to approve the application of the nurse to engage in independent practice without written guidelines or protocols and/or to have independent prescriptive authority.

**F. Optician:** A **State Business License** issued by the Division of Revenue is required for opticians located in the state of Delaware. A local business license is also required if required by the city/town in which the provider is located. Opticians located in a state other than Delaware are required to submit a license issued by a comparable certifying agency (if applicable).

**G. Orthodontist:** A **Certificate of Advanced Training** from an ADA approved program is required in addition to a professional license.

**H. Private Duty Nurse:** A copy of the policy declaration for professional liability insurance is required in addition to a professional license.

- I. **Speech-Language Pathologist: A Certificate of Clinical Competence in Speech-Language Pathology** is required in addition to a professional license.

**DSP Provider Specific Attachments:**

- A. **Nutritionist/Dietician: Certification** issued by the Delaware Committee of Dietetics/Nutrition or a comparable certifying agency is required.
- B. **Substance Abuse Counselor: Certification** issued by the International Certification & Reciprocity Consortium, the Delaware Certification Board or a comparable certifying agency is required.

## Part 5 – Diamond State Partners Application



**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:**

<b>Male only</b>	<b>Female only</b>	<b>Both Male &amp; Female</b>
------------------	--------------------	-------------------------------
  
- **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:

**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**