



Delaware Physicians Care, Incorporated  
 252 Chapman Rd., Ste 250  
 Newark, DE 19702  
 Fax: 866-946-6066

Dear Provider:

We are committed to the quality of health care services delivered to our members, so we have a well-defined and structured facility credentialing process in place. Below, you'll find the information we need to complete our credentialing process, as required by Delaware Physicians Care, Incorporated (DPCI).

Please complete and submit the information requested in its entirety (including this letter) via fax to 866-946-6066 or mail to the address above within **five (5) business days**.

Facility Provider Type:	
Facility/Organization Name:	
Service Location Address:	
Primary Phone#:	
Contact Name:	Contact Fax#:
NPI#:	

- Signed and Dated Attestation (bottom of questionnaire)
- A copy of the facility's current W-9. Tax ID Number (TIN): \_\_\_\_\_
- Medicare Certification Number: \_\_\_\_\_  
 Medicare Part A OR  Medicare Part B OR  Medicare Part C (Ambulatory Surgery only)
- Copy of current Facility State License, Business Registration, or Certificate of Occupancy (if applicable)
- Copy of accreditation or certification certificates or letter (if applicable). Refer to page 2.
- If facility is not accredited, provide most recent CMS or State Survey/Inspection Report including Corrective Action Plan and compliance letters.
- Copy of Clinical Lab Improvement Amendment (CLIA) – (for laboratories only)
- A copy of the Malpractice Liability Insurance Certificate including limits and expiration date or details below:
- Delaware Physicians Care, Incorporated Credentialing Application Addendum

<b>PROFESSIONAL LIABILITY INSURANCE COVERAGE</b>	
Do you have Professional Liability (Malpractice) Insurance coverage in force? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide a copy of current Professional Liability Insurance Certificate, including Carrier's Name, effective and expiration dates, policy number, and liability dollar limits or provide details below:	
Name of Insurance Carrier/Insurer:	
Policy effective date:	Policy expiration date:
Policy Number:	
Amount of coverage per occurrence: \$	Amount of coverage per aggregate: \$

\*For information obtained during verification from primary sources, as a practitioner, you have the right to correct discrepant or erroneous information by working directly with any reporting entities used during the credentialing process.

**If you have additional information or additional insurance coverage, please provide below:**

- Additional Professional Liability     
  Self Insured Retention     
  Excess Coverage     
  Umbrella

Name of Insurance Carrier/Insurer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy expiration date: \_\_\_\_\_

Amount of Coverage per occurrence: \$ \_\_\_\_\_ Amount of coverage per aggregate: \$ \_\_\_\_\_

Do you have an Advance Directive policy?  Yes  No

**Hospital, Nursing Homes, Home Health Care Agency and Skilled Nursing Facility:** If you responded No, please include a copy of the specific section of your policy/process, which addresses that you do not maintain Advance directive policies. You do not have to include the complete policy.

Please check the applicable box(es) below that describe your facility type and circle applicable accreditation or certification. If applicable, please provide copy of certificate.

- |   |                            |
|---|----------------------------|
| <input type="checkbox"/> Hospital   | TJC or HFAP                |
| <input type="checkbox"/> Children's Hospital  | TJC or HFAP                |
| <input type="checkbox"/> Long Term Acute Care Hospital                                    | TJC or HFAP                |
| <input type="checkbox"/> Nursing Home   | TJC or CARF or CCAC        |
| <input type="checkbox"/> Skilled Nursing Facility   | TJC or CARF                |
| <input type="checkbox"/> Home Care Agency   | TJC or CHAP or ACHC        |
| <input type="checkbox"/> Hospice Agency   | TJC or CHAP or ACHC        |
| <input type="checkbox"/> Free Standing Surgical Center                                    | TJC or AAAHC or AAAASF     |
| <input type="checkbox"/> Voluntary Interruption of Pregnancy Center                       |                            |
| <input type="checkbox"/> Urgent Care Facility   |                            |
| <input type="checkbox"/> Mental Health Hospital   | TJC or CARF or HFAP or COA |
| <input type="checkbox"/> Chemical Dependency/Substance Abuse Hospital                     | TJC or CARF or HFAP or COA |
| <input type="checkbox"/> Community Mental Health Center                                   | TJC or CARF or HFAP or COA |
| <input type="checkbox"/> Residential Treatment Facility                                   | TJC or CARF or HFAP or COA |
| <input type="checkbox"/> Partial Hospitalization Program                                  | TJC or CARF or HFAP or COA |
| <input type="checkbox"/> Intensive Outpatient Programs and Clinics                        | TJC or CARF or HFAP or COA |
| <input type="checkbox"/> Crisis Stabilization Program                                     | TJC or CARF                |
| <input type="checkbox"/> Laboratory   | CLIA                       |
| Facility is a Draw Site only? <input type="checkbox"/> Yes or <input type="checkbox"/> No |                            |
| <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility                 | TJC or CARF                |
| <input type="checkbox"/> Outpatient Physical Therapy Facility                             |                            |
| <input type="checkbox"/> Outpatient Speech Pathology                                      |                            |
| <input type="checkbox"/> Outpatient Diabetics Self-Management Training Providers          | ADA or IHS                 |
| <input type="checkbox"/> End-Stage Renal Dialysis Center                                  |                            |
| <input type="checkbox"/> Portable X-Ray Suppliers   | FDA                        |
| <input type="checkbox"/> Federally Qualified Health Care Centers                          |                            |
| <input type="checkbox"/> Rural Health Clinics   |                            |
| <input type="checkbox"/> Other: _____   |                            |

\*For information obtained during verification from primary sources, as a practitioner, you have the right to correct discrepant or erroneous information by working directly with any reporting entities used during the credentialing process.

Please fax or mail this completed letter to the address on this letterhead. If you have questions regarding this request please call DPCI Provider Relations at (800)287-9860.

Sincerely,

Delaware Physicians Care, Incorporated

### **Attestation**

It is understood that the burden of providing adequate information to Delaware Physicians Care, Incorporated to demonstrate compliance with Delaware Physicians Care, Incorporated's credentialing process falls upon the individual signing below. It is understood and agreed upon that any misstatement or material omission in this questionnaire will constitute grounds for rejection or termination from the Delaware Physicians Care, Incorporated network. If any material changes occur in the information that has been provided making the above information no longer correct and complete, it is understood and agreed upon that it is my obligation to notify Delaware Physicians Care, Incorporated within (15) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection or termination from the Delaware Physicians Care, Incorporated network.

I certify that the information contained in this survey and all attachments is accurate, complete and true.

Name:	Signature(s):
Title:	Date:

\*For information obtained during verification from primary sources, as a practitioner, you have the right to correct discrepant or erroneous information by working directly with any reporting entities used during the credentialing process.



**DELAWARE PHYSICIANS CARE, INC.  
APPLICATION ADDENDUM (*Institutional Providers*)<sup>1</sup>**

Instructions

- This addendum must be completed by all institutional provider applicants, in addition to the main application. Use extra pages as needed.
- Institutional providers include hospitals, SNFs, home health agencies, renal disease facilities, clinical labs, rural health clinics, IPAs, and all other institutional providers

**Section 1**

1.1 For the 5-year period ending on the date you complete this Addendum, list any significant business transactions:

(a) between you/your practice and any supplier wholly owned by you/your practice:

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(b) between you/your practice and any subcontractor:

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[42 C.F.R. Section 455.105(b)(2)]

1.2. Disclose the identity (including full name and address) of each person who (a) has an ownership or control interest\* in you/your practice, or is your/your practice's agent or managing employee, **and** (b) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program:

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[42 C.F.R. Section 455.106(a)]

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<sup>1</sup> The Delaware Health and Social Services Division of Medicaid & Medical Assistance has required the collection of this information in order to comply with federal regulations.

**Section 2**

Disclose the following:

(a) The name and address of each person with an ownership or control interest\* in you or has an ownership or control interest in any subcontractor in which you have a direct or indirect ownership of 5% or more:

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(b) Whether any of the persons named in subsection (a) of this question are related to one another as spouse, parent, child or sibling:

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(c) The name of any other institutional provider in which a person with an ownership or control interest<sup>2</sup> in you also has an ownership or control interest. (You must request this information in writing from the person and retain copies of your written requests and all responses)

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[42 C.F.R. Section 455.104(a)]

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<sup>2</sup> A “person with an ownership or control interest” means a person or corporation that (a) has an ownership interest totally 5% or more in the disclosing entity; (b) has an indirect ownership interest equal to 5% or more in the disclosing entity; (c) has a combination of direct and indirect ownership interest equal to 5% or more in the disclosing entity; (d) owns an interest of 5% or more in any mortgage deed of trust, note or other obligation security by the disclosing entity if that interest equals at least 5% of the value of the disclosing entity’s property or assets; (e) is an officer or director of the disclosing entity if organized as a corporation; or (f) is a partner in the disclosing entity if organized as a partnership.

For more information, see 42 C.F.R. Section 455.102.