



## Application Process

Delaware Physicians Care, Incorporated (DPCI) is committed to the quality of health care services delivered to our members. In support of this commitment, we have structured provider credentialing and contracting processes in place.

Practitioners wishing to apply for participation in the DPCI network should complete and return the DPCI Practitioner Application Screening Form in its entirety. As a participant with the Council for Affordable Quality Healthcare (CAQH), DPCI utilizes the CAQH uniform provider application.

- Practitioners **joining an existing, participating DPCI provider practice** should complete, sign and return the attached DPCI Participating Health Provider Agreement Attachment C **and** the Practitioner Application Screening Form.
- Practitioners applying for participation with DPCI **as a new provider** should complete and return just the DPCI Practitioner Application Screening Form.. Our Network Development department will follow up with your office with DPCI contract documents, as appropriate.

If you have a current CAQH application on file, be sure to include your CAQH ID # on the Application Screening Form.

Please fax all completed documents to DPCI at **866-946-6066**, or by mail to: **Delaware Physicians Care 252 Chapman Rd, Suite 250, Newark, DE 19702**.

DPCI assesses all provider applicants before initiating credentialing and contracting processes. After an initial review of the application prescreening form, providers will be sent either 1) DPCI Participating Health Provider (PHP) Agreement (contract) (if one is not already on file) or 2) notification in writing, if DPCI determines the provider is unable to join the network.

The following steps must be successfully completed for providers to be eligible to provide care to DPCI members:

- 1) The Practitioner Application Screening Form must be submitted correctly and completely.
- 2) Provider must be fully credentialed by DPCI.
- 3) New providers will be mailed a DPCI contract. Providers joining an existing group must complete the applicable contract documents to be added to the existing contract.
- 4) Provider must sign and return the DPCI contract documents.
- 5) When credentialing is complete and contract documents have been fully executed, the provider will receive notice from DPCI's Network Development department with the provider's effective date of participation, along with the fully executed contract (if it is a new contract).
- 6) Providers should refrain from scheduling and seeing DPCI members until you are notified of your participation effective date.

***You will be notified of your participation effective date with DPCI when the full credentialing and contracting process is complete.***

Please contact your Provider Relations representative with any questions about DPCI's provider application process at 1-800-287-9860.



**Practitioner Application Screening Form**  
**COMPLETE ONE FORM PER PRACTITIONER IN PRACTICE**  
**Fax the completed form to (866) 946-6066, or send by mail to:**  
**Delaware Physicians Care**  
**Attn: Network Development – Screening Form**  
**252 Chapman Road, Ste 250**  
**Newark Delaware 19702**

**Delaware Physicians Care, Incorporated's (DPCI)** contracting and credentialing standards require that DPCI obtain personal information such as your name, address, and social security number. Personal information is maintained in contracting and credentialing databases at DPCI for in-house tracking, reporting purposes, contracting, credentialing and payment of claims. Providing the required personal information is voluntary; however, failure to provide it will delay the contracting and credentialing process.

IN ORDER TO BE CONTRACTED, **YOU MUST: HAVE AN INDIVIDUAL NPI NUMBER, BE ELIGIBLE TO PARTICIPATE IN MEDICAID, COMPLETE THE CREDENTIALING PROCESS (if applicable) AND HAVE HOSPITAL PRIVILEGES AT A DELAWARE HOSPITAL (if applicable).** *W-9 forms for each Doing Business As (DBA) entity is required in order to establish/recognize all billing entities and/or the official Tax Identification Number (TIN) owner. Additionally, please note the establishment/recognition of multiple DBA/billing entities under one TIN require a unique billing NPI for each DBA/business entity.*

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Provider Info</b>				
	(Last Name)	(First Name)	(Middle Initial)	(Degree)
	Male    Female			
	Gender	Date of Birth	Social Security Number	Practice Name
	Joining as:            Individual            Group	An Existing Group:    Y    N		A New Provider:    Y    N
	DBA (Doing Business As) Name:			
<b>Practicing Specialties</b>	Primary Specialty:		Secondary Specialty:	
	Provider Type :			
<b>Malpractice Coverage</b>	Minimum Malpractice Coverage (\$1M/\$3M):    Y    N		FTCA (Federal Tort Claims Act):    Y    N	
	Malpractice Carrier:		Policy Number:	
	Are you a primary care physician?    Y    N		If Yes, are you accepting new members?    Y    N	
<b>Practice Panel Limits</b>	Maximum number of new members accepted:			
	Do you have age limits for practice?    Y    N		If Yes, what are the limits?	
<b>National Practitioner Identification (NPI)</b>	Group/Billing NPI:		Individual NPI:	
<b>Other ID's *must be current</b>	DEA # (Drug Enforcement Administration):		CAQH# (Council for Affordable Quality Health Care):	
	State(s) License #:	Effective Date: Term Date:	State(s) Licensed:	Effective Date: Term Date:
<b>Language and Culture</b>	Language(s) spoken other than English:    Y    N		Primary:	
			Secondary:	

<b>Hospital Affiliates</b>	Active    Courtesy    Delivery    Pending    Provisional
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<b>Hospital Affiliates</b>		Active    Courtesy    Delivery    Pending    Provisional
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*\*Add other Hospital Affiliates or names on a separate attached sheet*

<b>Primary Address:</b> (Main location where provider offers services)	Practice Name:			
	Address 1:		Address 2:	
	City:	State:	County:	Zip Code:
	Phone:	Fax:	Email Address:	
	Contact Name:		Contact Phone:	Handicap Accessible:    Y    N
<b>Mailing Address</b>  Check if same as primary address <input type="checkbox"/>	Practice Name:			
	Address 1:		Address 2:	
	City:	State:	County:	Zip Code:
	Phone:	Fax:	Email Address:	
	Contact Name:		Contact Phone:	

*\*Add other practice offices and demographics on a separate attached sheet*

**The completion of this form does not guarantee network participation.** Network participation will depend on the network need of DPCI and the successful completion of our credentialing process.

I am \_\_\_\_\_ of \_\_\_\_\_ and authorized to submit this application on behalf of \_\_\_\_\_. I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I Promise to keep confidential any information that DPCI shares with me during this process.

**Authorized Signature:** \_\_\_\_\_      **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please Do Not Write Below This Line – Credentialing Representative Only**

Practitioner Type:     Specialist     PCP     BH     Allied/Ancillary Provider

Credentialing required:     Yes     No

Date received from Network Development: \_\_\_\_/\_\_\_\_/\_\_\_\_

Received by:

**DELAWARE PHYSICIANS CARE, INCORPORATED**  
**PARTICIPATING HEALTH PROVIDER AGREEMENT**  
**ATTACHMENT C**  
**LIST OF HEALTH PROFESSIONALS**  
**AND ACCEPTANCE OF TERMS**

Page \_\_ of \_\_

PHP/Group Name \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Federal Tax ID Number \_\_\_\_\_

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

Group NPI \_\_\_\_\_

Email Address: \_\_\_\_\_ Date \_\_\_\_\_

This Attachment C. must be completed if PHP is an entity, or if PHP is an individual, and a Health Professional other than PHP will perform Covered Services. This Attachment C, as may be amended from time to time, shall list the Health Professionals who (i.) own, are employed by, or under contract with, the PHP, including locum tenens; and (ii.) will perform Covered Services under this Agreement. Each Health Professional listed on this Attachment C. must sign the Acceptance of Terms at the end of this Attachment C. to indicate that the Health Professional agrees to provide Covered Services pursuant to the terms of this Agreement. PHP may amend this Attachment C. by giving DPCI at least ninety (90) days advance written notice of the Health Professional's addition to or deletion from the list below. PHP may only add a Health Professional that DPCI has determined meets DPCI credentialing criteria. A deletion does not require PHP to deliver a new Attachment C. An addition requires PHP to deliver a supplemental Attachment C containing the following information about the new Health Professional(s) and a signature page for the new Health Professional(s) on the Acceptance of Terms By Health Professional form but does not require new signatures by existing Health Professional(s).

Provider Name	Specialty	Medical License Number	NPI Number	Tax ID Number	BNDD-DEA#

**DELAWARE PHYSICIANS CARE, INCORPORATED**  
**PARTICIPATING HEALTH PROVIDER AGREEMENT**  
**ATTACHMENT C**  
**LIST OF HEALTH PROFESSIONALS**  
**AND ACCEPTANCE OF TERMS**

**ACCEPTANCE OF TERMS BY HEALTH PROFESSIONAL**

In consideration of the opportunity to perform Covered Services under the Participating Health Professional Agreement between DPCI and the PHP listed on the signature page of this Agreement (the "Agreement"), the undersigned accept and agree to be bound by the terms and conditions of the Agreement, with the same effect as if the undersigned had personally executed the Agreement. The undersigned acknowledge that the Agreement contains certain requirements that a Health Professional under the Agreement must follow at all times, including that the Health Professional must:

- a. be fully licensed to practice medicine in State without restriction and without being subject to any disciplinary or corrective action;
- b. maintain without restriction or limitation certification and authorization as a Medicare and State Medicaid program provider, with no sanctions, debarment or exclusion under any federal healthcare program, and no convictions of any felony or any healthcare offense;
- c. maintain without restriction or limitation all customary narcotics and controlled substances numbers and licenses;
- d. maintain without restriction or limitation privileges at a State-licensed hospital;
- e. continuously meet all credentialing requirements imposed by DPCI;
- f. continuously follow all Applicable Law DPCI Policies and obligations and requirements of DPCI under the DPCI Contract; and
- g. be continuously covered by professional liability insurance as set forth in Attachment A, Section III. of this Agreement.

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

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Typed Name \_\_\_\_\_