DELAWARE SCREENING FOR LIFE PROGRAM
PROVIDER ENROLLMENT APPLICATION

Application Date:	
SFL Site Number	

Section 1 Primary or Secondary Provider: *Primary provider defined as any healthcare provider who orders tests, receives test results and notifies the clients of results.							
Please check one type of provider only.		*Primary Provider			Secondary Provider		

Section 2 Provider Enrollment Status: Please check appropriate space.											
New Enrollment:			Re-Enrollment:			Name Change:			Reinstatement:		

Section 3 Practice Contact Information:			
3a) Practice or Office Name:			
3b) Street Address:			
3c) City:	**3d) State:**	**3e) Zip Code:**	**3f) Tax ID number:** (number on W9)

3g) Telephone number:	**3h) Fax number:**
3i) Office Contact Person:	**3j) Email Address:**

Section 4 List of providers whose services will be billed under this contract: A provider may be defined as a group or individual that provides a medical service that relates to the SFL program.		
	4a) List Names:	**4b) National Provider Identification Number (NPI):**
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Section 5 What SFL services will this site provide? Please check appropriate box in each area.

5a) Breast:		5b) Cervical:		5c) Colorectal:		5d) Prostate:	
Office Visit		Office Visit		Office Visit		Office Visit	
Consultation Visit		Consultation Visit		Consultation Visit		Consultation Visit	
Surgical Pathology		Surgical Pathology		Surgical Pathology		Surgical Pathology	
Anesthesia		Anesthesia		Anesthesia		Anesthesia	
Breast Biopsy		Colposcopy		Digital Rectal Exam		Digital Rectal Exam	
Breast Ultrasound		HPV Vaccine		Fecal Occult Blood Test		Prostate Specific Antigen	
Eval/Inter of FNA				Barium Enema		Prostate Ultrasound	
				Flexible Sigmoidoscopy		Prostate Biopsy	
				Colonoscopy			

5e) Lung:	
Office Visit	
Consultation Visit	
Surgical Pathology	
Anesthesia	
Low Dose Computerized Tomography	
Lung Biopsy	
Excision	
Resection	

5e) MQSA Certification: Please identify your **MQSA** certificate by placing your facility ID number in the appropriate box and identify its start and expiration date.

Facility ID Number:		MQSA Expiration Date:	

5f) CLIA Certification: Please include your **CLIA** certificate number by placing it in the appropriate box and identify its start and expiration date.

CLIA ID Number:		CLIA Effective Date:	
		CLIA Expiration Date:	

*Please include copy of certificate(s) if applicable

Section 6 Billing Contact Information: All applicants must complete this section. Address below is where Screening for Life will mail payments.

6a) Company Name:

6b) Address:

6c) City:	**6d) State:**	**6e) Zip Code:**
6f) Telephone number:	**6g) Fax number:**	
6h) Billing Contact Person:	**6i) Email Address:**	

Section 7 Credentialing Contact Information: Complete this section if office has separate credentialing contact and/or location. Address below is where Screening for Life will mail/email Renewal Forms.		
7a) Company Name:		
7b) Address:		
7c) City:	**7d) State:**	**7e) Zip Code:**
7f) Telephone number:	**7g) Fax number:**	
7h) Contact Person:	**7i) Email Address:**	

Section 8 Secondary Facilities Utilized: must also be a participating Screening for Life Provider					
8a) Cytology Laboratory Names:					
1)					
2)					
3)					
8b): Laboratory fees for the Pap Smears should be paid: Please check appropriate box below.					
Directly to the Laboratory:			To the Primary Provider:		
8c) Mammography Facility Names:					
1)					
2)					
3)					
8d) Anesthesia Facility Names:					
1)					
2)					
3)					

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Please return this form along with three signed agreements and a W-9 to:
Screening for Life
Thomas Collins Bldg., Suite 11
540 S. DuPont Highway
Dover, DE 19901
Tel: 302-744-1040

Complete a W-9 online at https://w9.accounting.delaware.gov/

Important note: Applicants are not authorized participating providers until a provider site number is assigned by Screening for Life and all agreements have been signed by a representative of the Division of Public Health.

Thank you for your interest in the Screening for Life program.