



## Cost Recovery Documentation

Dear Colleague:

Under an agreement between DSCYF and Delaware Medicaid, DSCYF is the exclusive provider of Medicaid behavioral health and substance abuse services to children in Delaware.

In order for DSCYF's Cost Recovery Unit to pursue Medicaid reimbursement for services we provide to Delaware children through a third party such as your organization, we must obtain certain documentation from you annually. In your Contract or Statement of Agreement (Article I, Section B.5) with DSCYF you agree to provide this information.

We are requesting the following:

1. **Required: 3 GREEN FORMS** – These are standard forms that we require all of our providers to complete and sign annually (*including mental health subcontractors*).
  - **Rate Certification Form Residential** - Please provide the “**usual and customary rate**” that you charge to the general public for the services you have contracted with DSCYF. These rates *may be different* from the DSCYF Contracted Rates.  
Per Federal Regulations, DSCYF can only receive Medicaid reimbursements at or below the **usual and customary rate** that is charged to the general public. (*42 CFR 447.271 - Upper Limits Based on Customary Charges*)  
**NOTE:** If you have rate information already prepared and do not want to handwrite your rates on this form, please attach your rate information to the **signed** Rate Certification Form.
  - **CMS Sanctions Certification Form**
  - **Accreditation Status Form**
  
2. **Required: Copies of Licenses, Certificates, Accreditations, and NPI Letter**
  - **Professional Licenses:** If you are a clinician in private practice, please send a copy of your current professional license.
  - **Facility Licenses:** Different states use different wording for each type of license. Examples of facility licenses and/or certificates we need include, but are not limited to: Alcohol & Drug, Child & Youth Agency, Child Caring Institution, Child Placing Agency, Day Treatment, Foster Care, Group Home, Hospital, Outdoor program, Private Child & Youth Agency, Psychiatric Hospital, Residential Services, Residential Treatment, and Residential Childcare.
  - **Accreditations:** Please send a copy of any accreditation you may have. For JCAHO accreditation, send a copy of the JCAHO certificate and a copy of the JCAHO letter that specifies the effective month, day and year of the accreditation.
  - **NPI Letter:** Please send a copy of your NPI assignment letter or NPI assignment email.
  
3. **Other Required Forms:**
  - **Attending Physician Form** – Required Under HIPAA

*State of Delaware*

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*The Department of Services for Children, Youth and Their Families (DSCYF)  
Division of Management Support Services – Cost Recovery Unit (CRU)*

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**4. Other Information:**

- Any additional program or rate information that will help us in our Medicaid recovery efforts would be greatly appreciated.
- Please return the completed, signed, GREEN FORMS (originals), copies of licenses and certificates, other required forms, and any other information with your signed contract.

Or, you can mail them directly to:

State of Delaware  
DSCYF - DMSS  
Cost Recovery Unit  
1825 Faulkland Road  
Wilmington, DE 19805  
Attn: Charlotte Martin, MA II

If you expect a delay of more than two weeks in your response, or if you have any questions, please contact me.

The funds we recover from Medicaid allow us to provide more services, through you, to the children of Delaware.

Thank you for your cooperation.

Sincerely yours,

Charlotte Martin, Management Analyst II  
DSCYF-DMSS  
Cost Recovery Unit  
Phone: 302-892-4567  
Fax: 302-633-5113  
E-mail: [charlotte.martin@state.de.us](mailto:charlotte.martin@state.de.us)

Enclosures: 4



**RATE CERTIFICATION FORM - Residential  
Usual and Customary Charges to the General Public**

Complete a separate form for each location for which services are contracted by DSCYF. A campus consisting of closely located cottages is considered one location. If a service is program funded and not per diem, please check Yes for “**Program Funded**” and skip Sections I and II.

Otherwise please list both your “**usual and customary rate**” and the “**DSCYF contracted rate**” for all services. If you operate an on-site education program as part of the residential treatment program, list the residential and therapeutic education rates separately. If the children attend public school, it is not necessary to list the public education cost.

<b>Contracting Division</b>	
<b>Contract ID (found on your DSCYF Contract)</b>	
<b>Contract Period</b>	
<b>Program Funded</b>	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>

**Section I**

<b>Do children in your residential program receive public education through your state’s public school system?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Where is the education provided?</b>	<input type="checkbox"/> On-Site	<input type="checkbox"/> Off-Site

**Section II**

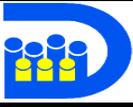
Program Name\Service Description	Healthcare Procedure Billing Code	Contracted DSCYF Rate	Usual & Customary Therapeutic Education Rate	Usual & Customary Residential Rate	Usual & Customary Total Rate

**Section III**

<b>Is your facility enrolled with Medicaid?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>If yes, which States?</b>		

**Section IV**

<b>Agency Name</b>	
<b>Name of Authorized Representative</b>	
<b>Title of Authorized Representative</b>	
<b>Signature of Authorized Representative</b>	
<b>Date</b>	
<b>Phone</b>	
<b>E-mail</b>	



**CMS SANCTIONS CERTIFICATION FORM**

Per the SOCIAL SECURITY ACT, SEC. 1128, 42 USC Sec. 1320a-7 “Exclusion of certain individuals and entities from participation in Medicare and State health care programs,” the Secretary of U.S. Department of Health and Human Services may exclude individuals and entities from participation in any Federal health care program, including Medicaid and Medicare, or any State health care program.

I, the undersigned, as an authorized representative of this agency, certify that this agency has never been sanctioned by the Centers for Medicare & Medicaid Services (CMS), formerly HCFA, or had a license revoked.

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

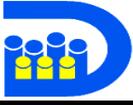
\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email address

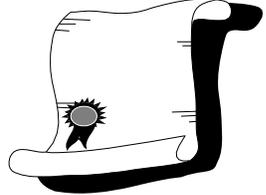
If your agency has ever been sanctioned, please provide details including date of reinstatement.

**SEND ORIGINAL (NOT PHOTOCOPIED) SIGNATURE ONLY.**

Return with contract or mail to: Cost Recovery Unit/DMSS/DSCYF  
1825 Faulkland Road, BMP 2120  
Wilmington, DE 19805  
302-892-4567 or 302-892- 4565



ACCREDITATION STATUS FORM



- This organization is not accredited.
- This organization is accredited.

\_\_\_\_\_  
Accrediting Organization(s)

From: \_\_\_\_\_ To: \_\_\_\_\_  
Period of Accreditation mm/dd/yy

Please detail which parts of your organization are covered by the accreditation standards (If your entire organization is accredited, it is only necessary to indicate "All" instead of providing a comprehensive list). In addition, please specify facility or campus names included in the survey (if applicable) within each service area.


PLEASE PROVIDE A COPY OF THE ACCREDITATION CERTIFICATE FOR OUR FILE

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of person completing form (please print)

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Email address



*Delaware Department of Services for Children, Youth, and Their Families  
Division of Management Support Services, Cost Recovery Unit  
1825 Faulkland Road, Wilmington, Delaware 19805*

Information on Treating Physician Required Under HIPAA

The Delaware Department of Services for Children Youth, and Their Families (DSCYF), Division of Child Mental Health Services, operates as a Managed Care Behavioral Health entity for Medicaid children in Delaware. We have a contract with Delaware Medicaid that allows us to provide public behavioral health services and to purchase services from private entities that meet our standards. We then bill Medicaid for those services.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health care claims be submitted on one of two acceptable formats. One of those formats, the 837 Institutional which is used for billing hospital and psych under 21 services, requires that we provide the Social Security number and Provider Taxonomy of the treating physician for services provided in hospitals such as yours. The Provider Taxonomy is a unique alphanumeric code, ten characters in length. The code list is structured into three distinct levels including Provider Type, Classification, and Area of Specialization.

**Please provide the information for the physicians treating DSCYF children or the physicians eligible to treat our children.**

The most commonly used Health Care Provider Taxonomies used by providers who treat DSCYF children are listed below.

A complete list can be found at <http://www.wpc-edi.com/codes/taxonomy>

2084P0800X - Psychiatry & Neurology: Psychiatry	2084P0802X - Psychiatry & Neurology: Addiction Psychiatry	2084P0804X - Psychiatry & Neurology: Child & Adolescent Psychiatry
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The Administrative Simplification provisions of HIPAA mandate the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique **National Provider Identifier (NPI)**. **NPI application forms can be found at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>**

LAST NAME	FIRST NAME	NATIONAL PROVIDER IDENTIFIER	PROVIDER TAXONOMY

Please complete, sign, and return this form to **[Charlotte.Martin@state.de.us](mailto:Charlotte.Martin@state.de.us)**, fax 302.633.5113, phone 302.892.4567, or mail to: DSCYF\DMSS\CRU 1825 Faulkland Rd, BMP 2120, Wilmington, DE 19805.

Thank you in advance for your assistance in this matter.

\_\_\_\_\_  
Facility Name

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

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

\_\_\_\_\_  
Date