



## Doula Practitioner Data Form Instructions

**Instructions:** On the enclosed Practitioner Data Form, please fill out Sections A, B, and C. If needed, attach additional pages. Please also submit the additional documents noted below. All information should be submitted to [Contracting@DelawareFirstHealth.com](mailto:Contracting@DelawareFirstHealth.com).

### **Section A – Provider Data:**

- Enter all provider data.
- Medicaid/MCD ID number.
- Doula Certification number.

### **Section B – Billing:**

- Enter billing information.

### **Section C – Demographics:**

- Enter service county(ies).

### **Additional Documents to Submit:**

- [W9](#) (with date and live signature).
- [Disclosure of Ownership and Control Interest Statement](#).
- Certificate of Insurance.

Section A: Provider Data		
Date Completed:	Individual NPI:	
Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, CAQH Provider ID:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Employer Identification Number:	Medicaid/MCD ID:
Title/Degree (MD, DO, NP, etc.):	(INTERNAL NOTE) DO NOT Display in Provider Directory	
Has Practitioner completed Cultural Competency Training? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, did the training include the following? African American <input type="checkbox"/> Yes <input type="checkbox"/> No    Asian <input type="checkbox"/> Yes <input type="checkbox"/> No    Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Alaskan Native <input type="checkbox"/> Yes <input type="checkbox"/> No    Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No    Pacific Islander <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Specialty:	Taxonomy Code:	Languages Spoken (including American Sign Language):
Doula Certification Number:	Certification Expiration Date:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Chinese <input type="checkbox"/> Arabic <input type="checkbox"/> ASL Other: _____

Section B: Billing		
Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

Section C: Demographics		
Servicing County 1:	Servicing County 2:	Servicing County 3:

**NOTE FOR INTERNAL CREDENTIALING/ENROLLMENT TEAM**

Doula credentialing for Delaware Medicaid reimbursement is performed by the Delaware Certification Board. Certification and exclusion checks for enrollment is performed by Delaware First Health. Do not display doula providers in the directory.