



*Guía de usuario de LaborFirst para
proveedores de atención médica*

Guía de usuario de LaborFirst para proveedores de atención médica

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Guía del usuario: Proceso de certificación de proveedores de atención médica

Las reclamaciones de **licencias por razones médicas o cuidado de familiares** requieren certificación por parte de un proveedor de atención médica. El proceso comprende lo siguiente:

1. El solicitante presenta una reclamación de licencia por razones médicas y familiares con goce de sueldo (PFML) a través de **LaborFirst**.
2. El solicitante le proporciona al proveedor de atención médica el código de identificación del formulario de certificación médica (**Form ID**).
3. El proveedor de atención médica completa la certificación en **LaborFirst**.

Recepción de correo electrónico con el Form ID

Después de presentar la reclamación, el solicitante recibe un correo electrónico con el código del formulario (**Form ID**). El correo electrónico incluye lo siguiente:

- **El Form ID**
- Instrucciones para completar la certificación de un problema de salud grave
- Enlaces y recursos útiles

El proveedor de atención médica debe usar este código de identificación para acceder al formulario de certificación.

PFML Health Care Provider Certification Form ID Claim ID CLM-00001308



LaborFirst <laborfirstnotifications@delaware.gov>
To ○ Samuel Smokrovich

ⓘ This sender laborfirstnotifications@delaware.gov is from outside your organization.



Tue 10/28/2025 3:45 PM

October 27, 2025

Hello Paul Bishop,

You applied on October 27, 2025 for leave for your family member's serious health condition.

To complete your claim, please give your Health Care Provider a copy of this email. They will need the Form ID below to fill out the Certification of Serious Health Condition.

Form ID: d3ff7edd-9e1e-4e98-89d4-445990a177d3

Important information for your Health Care Provider:

- The Certification of Serious Health Condition form must be completed electronically. Use this [link](#). You can also find this form on the Delaware LaborFirst website [Delaware Paid Leave - Delaware Department of Labor](#).
- Enter the unique Form Id listed above.
- Fill out all required patient information.

Please contact the Division of Paid Leave at PFML@delaware.gov if you have any questions.

Regards,

Chris Counihan
Director, Division of Paid Leave
Delaware Department of Labor
24/7/365 Call Center: (302) 761-8375
Email: PFML@delaware.gov



Correo electrónico

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Ingreso del Form ID

Haga clic en el enlace público suministrado. Copie el código de identificación del formulario (**Form ID**) que se especifica en el mensaje de correo electrónico y péguelo en el campo designado. Seleccione **Next** (Siguiente) para continuar.

Enter Form ID

Please enter the Form ID that you received for this Certification of Serious Health Condition.

* Form ID

Steps

Enter Form ID

Next

Pantalla de ingreso del Form ID

Revisión de información importante

La pantalla **Important Information** (Información importante) brinda datos necesarios para la certificación. Lea detenidamente la información importante.

Después de revisarla, seleccione **Next** (Siguiente).

Important Information

You as the provider will need to provide some information about yourself before filling out the Certification of Serious Health Condition.

Once you have provided your information you will be presented with the Certification of Serious Health Condition where you will need to provide the following information about your patient:

- Date(s) of hospitalization, procedure(s), and treatment(s)
- Date(s) of planned hospitalization(s), procedure(s), and treatment(s)
- Frequency and/or duration of treatment and expected periods of recovery
- Medical necessity for patient or their family member's absence from work, including reduced hours in the workday and intermittent days off from work

Be sure to review the Claim Summary prior to completing the Certification.

Steps

Important Information

Health Care Provider Information

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Pantalla Important Information (Información importante)

Ingreso de información del proveedor de atención médica

Complete los campos de la sección **Personal Information** (Información personal):

Ingrese su nombre (**First Name**), apellido (**Last Name**) y datos de contacto, el tipo de consultorio/especialidad médica (**Type of Practice/Medical Specialty**), el número de identificación nacional de proveedor (**NPI Number**), dirección comercial (**Business Address**), ciudad (**City**), estado (**State**) y código postal (**Zip code**), y seleccione **Next** (Siguiente).

(Nota: Todos los campos con un asterisco rojo son obligatorios).

Health Care Provider Information

Personal Information

* First Name	Middle Name
<input type="text"/>	<input type="text"/>
* Last Name	Suffix
<input type="text"/>	<input type="text"/>
* Phone Number	Email
<input type="text"/>	<input type="text"/>
* Type of practice / Medical Specialty:	* NPI Number <small>(i)</small>
<input type="text"/>	<input type="text"/>

Business Address

* Address Line 1 <small>(i)</small>	* City
<input type="text"/>	<input type="text"/>
* State	* Zip/Postal Code
<input type="text"/>	<input type="text"/>

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Steps

- Important Information
- Health Care Provider Information**

Pantalla Health Care Provider Information (Información del proveedor de atención médica)

Revisión de información del paciente

La información del paciente (empleado o familiar) se completará automáticamente con los datos que figuran en el resumen de la reclamación (**Claim Summary**) y se mostrará en formato de solo lectura.

Seleccione el hipervínculo para consultar el resumen de la reclamación del solicitante. Después de revisar el resumen, marque la casilla de verificación que aparece más abajo para confirmar que revisó el resumen de la reclamación, y seleccione **Next** (Siguiente) para continuar.

Patient Information

This claim being filed is for: **Medical Leave**
Below is information on the claimant/patient that is requesting medical or family caregiving leave

▼ Claimant Information

First Name	Middle Name	Last Name
Larry		Lennon
Date of Birth	Employer Name	Job Title
12/01/1992	Training Employer	Training Lead
Essential Job Function		
Training newly hired employees		

Select the hyperlink to view the claimant's claim summary in order to proceed. (This will open in a new tab so you can view it as you complete the Certification of Serious Health Condition) [Claim Summary](#)

I have opened the claim summary

Steps

- Important Information
- Health Care Provider Information
- Patient Information**
- Health Care Provider Certification
- Amount of Leave Needed
- Summary
- Confirmation

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Pantalla Patient Information (Información del paciente)

Certificación del proveedor de atención médica

Primero, responda **Yes** (Sí) o **No** a la pregunta "Is this serious health condition related to a workers' compensation claim?" (¿Este problema de salud grave se relaciona con una reclamación de compensación de trabajadores?).

A continuación, ingrese los detalles del problema de salud del solicitante: la fecha de inicio y la duración prevista. Seleccione los problemas de salud que se ajusten a la lesión o enfermedad del solicitante. Si selecciona **None of the Above** (Ninguna de las anteriores), se determinará que la reclamación no cumple con los requisitos.

Seleccione **Next** (Siguiente).

Health Care Provider Certification

This claim being filed is for: **Medical Leave**
 Select the hyperlink to view the claimant's [Claim Summary](#) for your review

*Is this serious health condition related to a worker's compensation claim?
 Yes No

*Please indicate the date the serious health condition started *Please provide best estimate of how long condition will last

*Please select all applicable serious health conditions from the list below:

- Inpatient Care
- Incapacity plus Treatment
- Complications with Pregnancy
- Chronic Conditions
- Permanent or Long-Term Conditions
- Conditions Requiring Multiple Treatments
- None of the Above

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- Important Information
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- Amount of Leave Needed
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Pantalla Health Care Provider Certification (Certificación del proveedor de atención médica)

Ingreso de duración de licencia

Indique si la licencia es necesaria desde el punto de vista médico (**Yes/No**). Si la respuesta es **Yes** (Sí), haga clic en "**+ Add New**" (+ Agregar nuevo) en la sección "Leave Schedules" (Cronogramas de licencias) para ingresar los detalles de la licencia requerida.

Amount of Leave Needed

This claim being filed for: **Medical Leave**
 Select the hyperlink to view the claimant's **Claim Summary** for your review
 Based on the medical condition(s) previously selected, complete all that apply. Please provide your **best estimate** of the frequency and duration of a condition or treatment as well as the leave schedule needed. Be as specific as you can.

* Due to the condition(s), is it medically necessary for claimant to take leave?
 Yes No

[+ Add New](#)

Leave Schedules

Which Leave Schedule is Recommended	Start Date	End Date
-------------------------------------	------------	----------

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Steps

- ✓ Important Information
- ✓ Health Care Provider Information
- ✓ Patient Information
- ✓ Health Care Provider Certification
- **Amount of Leave Needed**
- Summary
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Pantalla Amount of Leave Needed (Duración necesaria de la licencia)

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Seleccione el tipo de licencia: Continuous (Continua), Reduced Hours Per Day (Horario reducido), Reduced Days Per Week (Semana reducida) o Intermittent (Intermitente). Ingrese las fechas de inicio y finalización, y seleccione **Save** (Guardar).

1. **Continuous:** A leave schedule in which leave is taken all at once in a single, uninterrupted block of time.
2. **Reduced Hours Per Day:** A leave schedule that allows a claimant to work fewer hours per day. Enter the percentage of a full workday the claimant can still work. Example: If they can work half the day, enter 50%.
3. **Reduced Days Per Week:** A leave schedule that allows a claimant to work fewer days per week. Enter the number of days the claimant can still work.
4. **Intermittent:** A leave schedule that allows leave to be taken in separate blocks of time on a periodic basis, rather than a continuous period of time. The blocks of time can vary in length. Example: The claimant may miss a few days of work each month when a chronic condition like migraines or asthma flares up.

*Which leave schedule is recommended for this claimant

Continuous Reduced Hours Per Day Reduced Days Per Week Intermittent

Example: Your regular work week is Monday through Friday, and you plan to take leave from January 12 ending January 26. In Delaware LaborFirst, a week is defined as Sunday through Saturday. To enter your leave correctly, select "Continuous" for the period of January 11 through January 24, since this covers two full weeks of leave. Then, create a separate leave period for the week of January 25 using the "Reduced Days Per Week" option, and select one day of leave for January 26.

January 2026

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3

Pantalla de detalles del cronograma de licencia

Una vez guardada la licencia, aparecerá en la sección "Leave Schedules" (Cronogramas de licencias). Seleccione **Next** (Siguiente) para continuar.

Amount of Leave Needed

This claim being filed for: **Medical Leave**
 Select the hyperlink to view the claimant's [Claim Summary](#) for your review
 Based on the medical condition(s) previously selected, complete all that apply. Please provide your **best estimate** of the frequency and duration of a condition or treatment as well as the leave schedule needed. Be as specific as you can.

* Due to the condition(s), is it medically necessary for claimant to take leave?

Yes No

[+ Add New](#)

Leave Schedules

Which Leave Schedule is Recommended	Start Date	End Date
Continuous	11/30/2025	01/10/2026

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Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed**
- Summary
- Confirmation

Pantalla con cronograma de una licencia seleccionada

Resumen

Revise y verifique toda la información ingresada. Marque la casilla de verificación, agregue su firma y la fecha, y seleccione **Next** (Siguiente).

Summary

- > Health Care Provider Information
- > Health Care Provider Certification
- > Amount of Leave Needed

* Please check this box to certify, under pains and penalties of perjury, that all information provided in this filing is complete and true to the best of your knowledge and belief.

* Signature

* Date

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Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed
- Summary
- Confirmation

Pantalla Summary (Resumen)

Confirmación

Aparecerá una pantalla con un código de confirmación (Confirmation Number). Guarde este número para sus registros. Seleccione **Finish** (Finalizar) para cerrar el proceso.

Confirmation

Confirmation Number: CON-38489

Thank you for submitting the Certification of Serious Health Condition to the Delaware Department of Labor, Division of Paid Leave on behalf of the claimant.

Please retain a copy of this confirmation for your records.

Finish

Steps

- Important Information
- Health Care Provider Information
- Patient Information
- Health Care Provider Certification
- Amount of Leave Needed
- Summary
- Confirmation

Pantalla Confirmation (Confirmación) con el código de confirmación