MEDI-CAL PROVIDER APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:

  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

- For Denti-Cal return completed forms to:

  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you***

FOR STATE USE ONLY

Provider number (NPI or Denti-Cal number as applicable): xxxxxxxxxx

Date: xx/xx/xxxx

Enrollment action requested **(check all that apply)**

- ☒ New provider
- ☐ Change of business address
- ☐ Additional business address
- ☐ New Taxpayer ID number
- ☐ Facility-Based Provider
- ☐ *Change of ownership (per Title 22, CCR, Section 51000.6)
- ☐ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
- ☐ *Sale of assets 50 percent or more, per Title 22, CCR, Section 51000.30)

For items above marked with * indicate effective date: ____/____/_____.

- ☐ Continued Enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)
- ☐ I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

***A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Indicate the change of ownership effective date: ____/____/_____.

Type of entity (check one)

- ☐ Sole proprietor
- ☒ Corporation:
  - Corporate number: xxxxxxxxx
  - State incorporated: xx
- ☐ Partnership (attach legible copy of agreement)
- ☐ Limited liability company (LLC):
  - LLC number: _____
  - State registered/filed: _____
- ☐ Government entity
- ☐ Nonprofit Corporation
  - Type of nonprofit: _____
- ☐ Other: _____

1. Legal name of applicant or provider (as listed with the IRS)
   Jane Doe, DDS INC
2. Business name, if different
   Happy Dental
3. Business telephone number
   (xxx)xxx-xxxx

Is this a fictitious business name? ☒ Yes ☐ No

If yes, list the Fictitious Business Name Statement/Permit number: FNP xxxx

Effective date: xx/xx/xxxx

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street)	City	County	State	Nine-digit ZIP code
555 Happy Street	Anytown	Anycounty	CA	xxxxx-xxxx

a. If you are applying as a **facility-based provider**, complete this section:

This address is a licensed hospital/health facility. ☐ Yes ☒ No

If yes, check the option that applies:

- ☐ All services are provided at this one facility location **OR**
- ☐ Services are provided at more than one licensed health facility

(Attach a list of all business addresses where services are provided).

5. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
555 Happy Street	Anytown	CA	xxxxx-xxxx
6. Mailing address (number, street, P.O. Box number)	**City**	**State**	**Nine-digit ZIP code**
N/A	N/A	N/A	N/A

For a change of business address, enter location moving from:

7. Previous business address (number, street)	City	State	Nine-digit ZIP code
N/A	N/A	N/A	N/A

8. License number (attach legible copy)	License effective date	License expiration date	9. Provider type	10. Medicare/Other NPI (see instructions)
xxxxx	xx/xx/xxxx	xx/xx/xxxx	Dentist	xxxxxxxxx

11. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code
N/A	N/A	N/A

12. Taxpayer Identification Number (TIN) issued by the IRS (attach a legible copy of the IRS form)	13. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 5.)
xx-xxxxxx	- - N/A

14. (Nurse Practitioner only) Duration of training program and school	15. (Nurse Practitioner only) Clinical and didactic training or equivalent experience completed
N/A	N/A

16. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy)	17. State Laboratory License/Registration number (attach a legible copy)	18. Driver's license or state-issued identification number and state of issuance (attach a legible copy)
N/A	N/A	N/A

19. **Proof of Liability Insurance—Applicant must attach a copy of their certificate of insurance for the business address.**

Name of insurance company: XYZ Insurance Company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)
xxxxxxxx	xx/xx/xxxx	xx/xx/xxxx

Insurance agent's name—(first)	(middle)	(last)	(Jr., Sr., etc.)
John	Q	Sample	

Telephone number	Fax number	E-mail address
(xxx)xxx-xxxx	(xxx)xxx-xxxx	JSample@fakeprovider.net

20. **Proof of Professional Liability Insurance—Applicant must attach a copy of their certificate of (malpractice) insurance to this application.**

Name of insurance company: XYZ Insurance Company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)
xxxxxxxx	xx/xx/xxxx	xx/xx/xxxx

Insurance agent's name—(first)	(middle)	(last)	(Jr., Sr., etc.)
John	Q	Sample	

Telephone number	Fax number	E-mail address
(xxx)xxx-xxxx	(xxx)xxx-xxxx	JSample@fakeprovider.net

21. Does the applicant have Worker's Compensation insurance as required by state law? ☒ Yes ☐ No ☐ N/A
If applicable, attach proof of maintenance of Worker's Compensation insurance. If not applicable, check N/A and provide an explanation below:

22. Date of birth	23. Gender	24. Any local business license numbers, permits (attach a legible copy(ies)) If N/A, provide explanation.	25. Seller's Permit number (attach a legible copy)
xx/xx/xxxx	☐ Male ☒ Female	xxxx	N/A

Information About Individual Signing This Application

26. Print name of applicant or provider or person signing the application on behalf of the applicant or provider. (last)	(first)	(middle)	27. Gender
Doe	Jane	G	☐ Male ☒ Female

28. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	29. Date of birth	30. Social security number (***Optional***—see Privacy Statement below.)
xxxxxxxx	xx/xx/xxxx	___ ___ ___ — N A — ___ ___ ___ ___

31. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR Section 51000.30(a)(2)(B).**

Signature of provider or person on behalf of the applicant or provider	Title
Jane Doe DDS	Dentist/Owner

Executed at: Anytown (City), CA (State) on 2/27/09 (Date)

32. Notary Public — Please see instructions under number 32 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

33. **Contact Person's Information**

☒ Check here if you are the same person identified in item 26. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (last)	(first)	(middle)	(gender)
			☐ Male ☐ Female

Title/Position	E-mail address	Telephone number
	JDoe@happydental.net	(xxx)xxx-xxxx

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945, or Denti-Cal at (800) 423-0507.