INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PROVIDER APPLICATION

DO NOT USE staples on this form or on any attachments.
DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.
DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is part of an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) and a Medi-Cal Provider Agreement (DHS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information or documentation on this form or failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Sections 51000.50.

Enrollment action requested—check all that apply. Enter the date you are completing the application.

"New provider"—check if the applicant is not currently enrolled in the Medi-Cal program and would like to have a Medi-Cal provider number issued.

"Change of business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

"Additional business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

"New Taxpayer ID number"—check if a new Taxpayer Identification Number (TIN) was issued by the IRS.

"Change of ownership"—check if there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

"Acceptance of Successor Liability with Joint and Several Liability"—check this box only if you are submitting this application pursuant to Title 22, CCR, Section 51000.32 and have already submitted or have enclosed a letter that meets the requirements of Section 51000.32(a)(1).

"Cumulative change of 50 percent or more in person(s) with ownership or control interest"—check if there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

"Sales of assets (50 percent or more)"—check if 50 percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

"Continued Enrollment"—check if the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current Medi-Cal provider number(s).

Check the box labeled "I intend to use my current . . . ." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51.

"Type of entity"—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check "other," list the type of legal entity.

1. "Legal name" is the name listed with the Internal Revenue Service (IRS).
2. "Business name" is the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application.
3. "Business telephone number" is the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.

4. “Business address” is the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office or commercial box is not acceptable.
5. “Pay-to address” is the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. “Mailing address” is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the license/certificate number, or other approval to provide health care, of the applicant or provider. Attach a legible copy of the license, certificate, or approval. Enter the effective date and the expiration date of the license/certificate number, or other approval.
8. Enter the provider type. See list in Title 22, CCR, Section 51051.
9. Enter the Medicare billing number. Attach verification of enrollment.
10. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
11. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 5.)
12. Nurse Practitioners only—enter the duration of the nurse practitioner training program and the school at which the nurse practitioner training program was completed.
13. Nurse Practitioners only—enter clinical and didactic training or equivalent experience completed.
14. Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA certificate. If this does not apply to you, enter “N/A”.
15. Enter the State Laboratory License/Registration number. Attach a legible copy of the license/registration. If this does not apply to you, enter N/A.
16. Enter the driver’s license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application. The driver’s license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
17. Proof of Liability Insurance—enter the name of the insurance company, insurance policy number, date policy issued, expiration date of policy, insurance agent's name, telephone number of the insurance agent, fax number of the insurance agent and email address of the insurance agent. You must attach a copy of your certificate of insurance for the identified business address to the application.
18. Proof of Professional Liability Insurance—enter the name of the insurance company, insurance policy number, date policy issued, expiration date of policy, insurance agent’s name, telephone number of the insurance agent, fax number of the insurance agent and email address of the insurance agent. You must attach a copy of your certificate of insurance to the application.
19. Check the appropriate box to indicate whether you have Worker’s Compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.
20. Enter the date of birth of the individual named in number 1, if applicable. If not applicable, enter N/A.
21. Check the gender of the individual named in number 1, if applicable. If not applicable, enter N/A.
22. Enter any local business license or permit numbers for any city and/or county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
23. Enter the Seller’s Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller’s Permit. If this does not apply to you, enter N/A.
24. “Printed name of provider”—print the last, first, and middle name of the person who is signing the application. The application must be signed by a person who is authorized to legally bind the provider or applicant.
25. Check the gender of the individual named in number 23.
26. Enter the driver’s license or state-issued identification number and state of issuance of the individual named in number 23. Attach a legible copy to the application.
27. Enter the date of birth of the individual named in number 23.
28. Enter the social security number of the individual named in number 23. Provision of the social security number is optional (See Privacy Statement on page 5).

29. An original signature of the individual named in number 23 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

30. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Driver's license or state-issued identification card
- ❒ TIN verification
- ❒ CLIA Certificate
- ❒ License, certification, or other approval
- ❒ Fictitious Business Name Statement/Permit
- ❒ State Laboratory License/Registration
- ❒ Signed Medi-Cal Provider Agreement (DHS 6208)
- ❒ Signed Medi-Cal Disclosure Statement (DHS 6207)
- ❒ Certificate of Liability Insurance
- ❒ Certificate of Professional Liability Insurance
- ❒ Proof of Worker's Compensation Insurance
- ❒ Medicare enrollment verification
- ❒ Successor Liability Agreement (if applicable)

MEDI-CAL PROVIDER APPLICATION

FOR STATE USE ONLY

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 Services
  Provider Enrollment Branch
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

  For Denti-Cal return completed forms to:

  Medi-Cal Dental Program
  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.***

Enrollment action requested (check all that apply)

Date / /

❒ New provider

For any of the following actions, include current Medi-Cal number: _____

❒ Change of business address
❒ Additional business address
❒ New Taxpayer ID number
❒ *Change of ownership (per Title 22, CCR, Section 51000.6)
❒ *Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
❒ *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)
❒ 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 Medi-Cal 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."**

Type of entity (check one)

❒ Sole proprietor
❒ Corporation:
Corporate number: _____
State incorporated: _____

❒ 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) (last) (first) (middle)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

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

Effective date / /

(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

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

Check the option that applies

b. ❒ All services are provided at this location.

c. ❒ I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all business addresses where the provider renders services.

5. Pay-to address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code

7. License number (attach legible copy) | License effective date / / | License expiration date / / | 8. Provider type | 9. Medicare billing number (attach a legible copy)

10. Taxpayer Identification Number (TIN) issued by the IRS (attach a legible copy of the IRS form) –

11. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 5.) – –

12. (Nurse Practitioner only) Duration of training program and school

13. (Nurse Practitioner only) Clinical and didactic training or equivalent experience completed

14. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy)

15. State Laboratory License/Registration number (attach a legible copy)

16. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

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

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy) / /	Expiration date of policy (mm/dd/yyyy) / /
Insurance agent's name—(first) (middle)	(last)	(Jr., Sr., etc.)
Telephone number ( )	Fax number ( )	E-mail address

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

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy) / /	Expiration date of policy (mm/dd/yyyy) / /
Insurance agent's name—(first) (middle)	(last)	(Jr., Sr., etc.)
Telephone number ( )	Fax number ( )	E-mail address

19. 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:

20. Date of birth / /	21. Gender ❒ Male ❒ Female	22. Any local business license numbers, permits (attach a legible copy(ies)) If N/A, provide explanation.	23. Seller's Permit number (attach a legible copy)

Information About Individual Signing This Application

24. Printed name of applicant or provider or person signing the application on behalf of the applicant or provider, or provider. (last) (first) (middle)	25. Gender ❒ Male ❒ Female

26. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	27. Date of birth / /	28. Social security number (***Optional***—see Privacy Statement below.) ___ ___ ___ — ___ ___ — ___ ___ ___ ___

29. **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.**

Signature of provider or person on behalf of the applicant or provider	Title

Executed at: _____, _____ on _____ / /
(City) (State) (Date)

30. Notary Public—Please see instructions under number 30 for who must notarize.

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 California Department of Health Services, Payment Systems 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 and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal 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 Provider Enrollment Branch, Payment Systems Division, at (916) 323-1945, or contact Denti-Cal at (800) 423-0507.