California Medi-Cal Dental Program

Denti-Cal Bulletin

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NO CLAIM ACTIVITY FOR 12 MONTHS

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period shall be deactivated per Welfare and Institutions Code Section 14043.62 which reads as follows:

> *The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted hereunder.*

If you have not had any claim activity in a 12-month period, and wish to remain an active provider in the Medi-Cal Dental Program, please complete the bottom portion of this form and mail to: Medi-Cal Dental Program, P.O. Box 15609, Sacramento, CA 95852-0609. If your provider number is deactivated, you must reapply for enrollment in the Medi-Cal Dental Program. To request an enrollment package contact Denti-Cal toll-free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

_____

Check the boxes that apply to your practice:

- ☐ AHK (Alameda Healthy Kids)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____ _____ _____

Provider Name Provider Number Provider Signature

_____

Provider Address City Zip Code

If your office has relocated, a new enrollment package must be submitted. Please check the box indicating your type of practice and Denti-Cal will send the necessary forms for completion:

☐ Group ☐ Individual