State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Pharmacy Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. This letter addresses information about the enrollment application process for a specific provider type.

PLEASE NOTE: Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Applicants are required to attach a copy of the Centers for Medicare & Medicaid Services (CMS)/National Plan and Provider Enumeration System (NPPES) confirmation for each NPI listed in the application package. If providers are not eligible to receive an NPI, they should instead enter the word "atypical" in any NPI fields. These “atypical providers” will receive a unique Medi-Cal provider number once the application is approved.

An application package must be submitted for all pharmacy providers new to the Medi-Cal program as well as all currently enrolled pharmacies subject to continued enrollment under *California Code of Regulations* (CCR), Title 22, Section 51000.55, or required to submit a new application package under CCR, Title 22, Section 51000.30, subsections (a) through (b).

Applicants and providers may be required to submit an application fee or proof of payment to or enrollment with Medicare or other state Medicaid programs. Effective January 1, 2013, the Department of Health Care Services (DHCS) requires certain applicants and providers to submit an application fee when requesting an enrollment action. The application fee collected is used to offset the cost of conducting the required screening as specified in Title 42 Code of Federal Regulations (CFR) 455 Subpart E. Please reference the Medi-Cal Regulatory Provider Bulletin, “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460,” for further information.

Due to the current 180-day moratorium, the DHCS is not accepting enrollment applications from pharmacies located in Los Angeles County, except for those eligible for an exemption. This moratorium ends on April 30, 2018, and is in accordance with *Welfare and Institutions Code* (W&I Code), Section 14043.55. As stated in the W&I Code, this moratorium may be continued when the DHCS Director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

If your business is a pharmacy located in Los Angeles County, and is eligible for an exemption according to the criteria outlined in the moratorium (located on the Provider Enrollment Division [PED] website at www.dhcs.ca.gov/provgovpart/Pages/PED.aspx), please complete a new application package consisting of a *Medi-Cal Pharmacy Provider Application* (DHCS 6205, Rev. 5/17), a *Medi-Cal Disclosure Statement* (DHCS 6207, Rev. 2/17), a *Medi-Cal Provider Agreement* (DHCS 6208, Rev. 2/17), **and a cover letter specifically stating the moratorium exemption that you qualify under, including information relating how you qualify for the exemption. A change of ownership application must include a copy of the sale agreement.**

Return the completed application package to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997412
Sacramento, CA 95899-7412

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned.

It is your responsibility to report to DHCS any modifications to information previously submitted within 35 days from the date of the change. Most changes can be reported on a *Medi-Cal Supplemental Changes* form (DHCS 6209, Rev. 10/16). However, you must complete a new application package if you are reporting a change of business ownership of 50 percent or more, a change of business address, or one of the other changes identified in CCR, Title 22, Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, the PED website contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled pharmacy, including the option to submit a *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217, Rev. 5/17).

Enrollment forms are available on the PED website or by contacting the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms, form completion and the regulatory requirements for participation in the Medi-Cal program, please visit the PED website. For additional enrollment questions, you may contact the PED Message Center at (916) 323-1945, ext. 4522, or submit your question(s) to the address above or via email to PEDCorr@dhcs.ca.gov.

Providers or provider representatives who intend to use the Medi-Cal Point of Service (POS) Network or Medi-Cal website applications must complete the *Medi-Cal Point of Service (POS) Network/Internet Agreement,* also available on the PED website, under the “Provider Forms” heading, then select “Billing Forms.”

Providers must request a submitter number in order to submit claims electronically by completing a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, Rev. 3/17), which is available at the same Billing location on the PED website. **A submitter number for an existing pharmacy is not transferable.** A new submitter number must be obtained each time a new Medi-Cal pharmacy provider number/NPI is issued. If you have any questions about completing the DHCS 6153 form, call the TSC at 1-800-541-5555 and select the option for Computer Media Claims (CMC).

Provider Enrollment Division

Enclosures (Rev. 11/17)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PHARMACY 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 (DHCS 6207) and a MEDI-CAL PROVIDER AGREEMENT (DHCS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

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 California Code of Regulations (CCR), Title 22, Section 51000.50.

You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for each National Provider Identifier (NPI) submitted with your application package. You may not submit an NPI for use in Medi-Cal billing unless that NPI is appropriately registered with CMS and is in compliance with all NPI requirements established by CMS at the time of submission.

You must submit an application fee and/or fee waiver request unless you are exempt from paying the fee. DHCS will only accept a cashier's check made payable to the State of California, Department of Health Care Services, in the amount required for the calendar year in which DHCS receives your application. Information regarding the current fee is available on the DHCS Web site at www.dhcs.ca.gov. Failure to submit a cashier's check when required may result in denial of your application.

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 as a provider with an active provider number. Include the NPI for the business address indicated in item 4.

"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 enrollment 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 CCR, Title 22, Section 51000.6.

"Acceptance of Successor Liability with Joint and Several Liability"—check this box only if you are submitting this application pursuant to CCR, Title 22, 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 ownership or control interest, as defined in CCR, Title 22, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment. Indicate the effective date in the space provided.

"Sale 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.

"New pharmacy permit" —check if a new pharmacy permit is required from the State Board of Pharmacy pursuant to Business and Professions Code (commencing with Section 4000).

"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 CCR, Title 22, Section 51000.55. List active 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 CCR, Title 22, Section 51000.51.

Medi-Cal Application Fee—check all that apply.

Check the box labeled "I am currently enrolled in the Medicare program…" if you are currently enrolled in the Medicare program at the business address indicated on page 9, item 4 of the application, and under the legal name listed on page 9, item 1 of the application. Provider locations are exempt from paying the fee if currently enrolled in Medicare pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. Verification is required: provide an official notice from the enrolling agency that specifies the applicant's/provider's legal name and physical business address as identified on this application.

Check the box labeled "I am currently enrolled in another State's…" if you are currently enrolled in another State's Medicaid or Children's Health Insurance Program (CHIP) at the business address indicated on page 9, item 4 of the application, and under the legal name listed on page 9, item 1 of the application. Provider locations are exempt from paying the fee if currently enrolled in another State's Medicaid or CHIP pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. Verification is required: provide an official notice from the enrolling agency that specifies the applicant's/provider's legal name and physical business address as identified on this application.

Check the box labeled "I have paid the application fee…" if you have paid the application fee to a Medicare contractor or another State's Medicaid or CHIP for the enrollment of the business address indicated on page 9, item 4 of the application, and under the legal name listed on page 9, item 1 of the application. Providers are exempt from paying the fee if they have already paid the fee to a Medicare contractor or another State's Medicaid or CHIP for the same business address pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. Verification is required: provide official proof of payment that specifies the applicant's/provider's legal name and physical business address as identified on this application.

Check the box labeled "I have included an application fee…" if you included with the application either an application fee cashier's check, fee waiver request, or both. Providers that do not meet the exemptions specified in the above boxes are required to pay the fee pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. **DHCS can only accept a cashier's check as payment of the application fee – made payable to the State of California, Department of Health Care Services.**

"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 phone, 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 address 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. "Previous business address" is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.
8. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
9. 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).
10. If the business is a sole proprietorship not using a TIN, enter the social security number of the sole proprietor. (See Privacy Statement on page 13)
11. Enter the California State Board of Pharmacy Permit number and expiration date. Attach a legible copy of the current 8½x11 permit.
12. Enter any other NPI for the business address indicated in item 4, registered with other carriers including, but not limited to Medicare. Attach CMS/NPPES confirmation for each.
13. Enter the applicant's or provider's Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
14. Enter any local business license/permit numbers. Attach a legible copy(ies) to the application.

15. Check the appropriate box and complete all requested information in this section.
16. Check the appropriate box and complete all requested information in this section.
17. Check the appropriate box regarding your ownership and/or leasehold interest in the building in which your business is located. If you lease the building, attach a copy of the written lease agreement. If anyone other than you holds an ownership interest in the building, enter the name(s), phone number(s), and address(es) of that person(s).
18. Check the appropriate box regarding whether you have the administrative and fiscal foundation to enable your business to survive as a going concern.
19. Check the appropriate box to indicate whether you have the necessary equipment, supplies and facilities to carry out your business and to comply with CCR, Title 22, Section 51476.
20. If the applicant or provider intends to bill the Medi-Cal program for durable medical equipment, complete this question by providing the following information:
    - Whether the applicant or provider does or does not have a retail business open to the public that meets all local laws and ordinances regarding business licensing and operations.
    - If this is not a retail business open to the public, explain why.
    - Whether the applicant engages in the sale, rental, and/or lease of items either in stock on the premises or in a warehouse under the applicant's direct control.
    - If the sales are of items housed in a warehouse under the applicant's or provider's direct control, enter the address of the warehouse.
    - The name(s), address(es), and telephone number(s) of any individual who holds an ownership interest in the warehouse. Use additional sheets if necessary.
21. Check the applicable box(es) corresponding to all business activities of the applicant or provider and give the percentage of each of those activities. Total the percentages. The percentages must total 100 percent. Calculate percentages based upon total dollar sales, including Medi-Cal, Medicare, all other third party payors, and cash transactions for the year immediately preceding filing of this application. If a change of 20 percent or more in total business activity is anticipated within the next year, compared to business activity in the year immediately preceding the filing of this Application, adjust the percentage listings to reflect this anticipated change. Enter the applicable registration, certificate, and license numbers and attach legible copies. NOTE: Pursuant to CCR, Title 22, Section 51315(e), pharmacists may furnish and bill for only those appliances listed in the Provider Manual and designated by double asterisks (**).
22. Check the appropriate box indicating whether the applicant or provider provides "custom rehabilitation equipment" and "custom rehabilitation technology services" to Medi-Cal beneficiaries. If you answer yes, check the appropriate box whether the applicant or provider has on staff, either as an employee or independent contractor, or the applicant or provider has a contractual relationship with, a "qualified rehabilitation professional" who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment. "Custom rehabilitation equipment" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.

"Custom rehabilitation technology services" means the application of enabling technology systems designed and assembled to meet the needs of a specific person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate, the documentation of medical necessity, the selection, fit, customization, maintenance, assembly, repair replacement, pick up and delivery, and testing of equipment and parts, and the training of an assistant caregiver and of a patient who will use the equipment or individuals who will assist the client in using the equipment.

"Qualified rehabilitation professional" means an individual to whom any one of the following applies:

(a) The individual is a physical therapist licensed pursuant to the Business and Professions Code, occupational therapist licensed pursuant to the Business and Professions Code, or other qualified health care professional approved by the Department.

(b) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers, or other credentialing organization recognized by the Department.

(c) The individual has successfully passed one of the following credentialing examinations administered by the Rehabilitation Engineering and Assistive Technology Society of North America:
  (i) The Assistive Technology Supplier examination.
  (ii) The Assistive Technology Practitioner examination.
  (iii) The Rehabilitation Engineering Technologist examination.

23. 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 e-mail address of the insurance agent. You must attach a copy of your certificate of insurance for the identified business address to the application.

24. Check the appropriate box to indicate whether you have Workers' Compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.

25. 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 e-mail address of the insurance agent. You must attach a copy of your certificate of insurance to the application.

26. Enter the first, middle, and last name of the pharmacist-in-charge at the business location.

27. Enter the license number of the pharmacist-in-charge. Attach a legible copy of the license.

28. Enter the driver's license or state-issued identification number and the state of issuance of the pharmacist-in-charge named in number 26. Attach a legible copy to this application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

29. Enter the social security number of the individual named in number 26. (Optional—See Privacy Statement on page 13)

30. Print the last, first, and middle name of the sole proprietor, partner, corporate officer or government official applying to the Department of Health Care Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
31. Check the gender of the individual named in number 30.
32. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 30. Attach a legible copy to the application.
33. Enter the date of birth of the individual named in number 30.
34. Enter the social security number of the individual named in number 30. (Optional—See Privacy Statement on page 13).
35. An original signature of the individual named in number 30 is required. Also enter the title of the person signing the application. Include the city, state, and the date where and when the application was signed. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this application.**
36. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.
37. To assist in the timely processing of the application package, enter the name, e-mail address, and telephone number of the individual who can be contacted by Provider Enrollment staff to answer questions regarding the application package. Failure to include this information may result in the application package being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

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

- ☐ Verification of enrollment in Medicare or another State's Medicaid/CHIP
- ☐ Proof of application fee payment to a Medicare contractor or another State's Medicaid/CHIP
- ☐ Fictitious Business Name Statement
- ☐ TIN verification
- ☐ Seller's Permit
- ☐ Any local business licenses/permits
- ☐ Licenses and certificates associated with business activities (as applicable):
  - ☐ Drug Enforcement Agency Controlled Substance Registration Certificate
  - ☐ Bureau of Home Furnishings and Thermal Insulation License
  - ☐ California State Board of Pharmacy Permit
- ☐ Pharmacist-in-charge license
- ☐ Driver's license or state-issued identification card for pharmacist-in-charge
- ☐ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ☐ Signed Medi-Cal Provider Agreement (DHCS 6208)
- ☐ Driver's license or state-issued identification card of individual signing the application
- ☐ Successor Liability Agreement
- ☐ Certificate of Liability Insurance
- ☐ Certificate of Professional Liability Insurance
- ☐ Proof of Workers' Compensation Insurance
- ☐ National Provider Identifier (NPI) verification (CMS/NPPES verification)
- ☐ Lease Agreement

MEDI-CAL PHARMACY 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.
- Return completed forms to:

  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997412
  Sacramento, CA 95899-7412
  (916) 323-1945
- **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.**

Provider number (NPI): _____

Date:

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

☐ New provider
☐ Change of business address
☐ Additional business address
☐ New Taxpayer ID Number
☐ *Change of ownership (per CCR, Title 22, Section 51000.6)
☐ *Acceptance of "Successor Liability with Joint and Several Liability" (per CCR, Title 22, Sections 51000.24.1, 51000.32)
☐ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per CCR, Title 22, Section 51000.15)
☐ *Sale of assets (50 percent or more) (per CCR, Title 22, 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 CCR, Title 22, 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 CCR, Title 22, Section 51000.51.

<u>*A provider agreement may not be transferred or assigned to another.</u>
However, an applicant may be joined to the provider agreement by strict compliance with the provisions of CCR, Title 22, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."
Indicate the change of ownership effective date: _____

Medi-Cal Application Fee (check all that apply)

☐ I am currently enrolled in the Medicare program at this business address and under this legal name. (Attach verification)

☐ I am currently enrolled in another State's Medicaid or Children's Health Insurance Program (CHIP) at this business address under this legal name. (Attach verification)

☐ I have paid the application fee to a Medicare contractor or another State's Medicaid or CHIP for this business address under this legal name. (Attach proof of payment)

☐ I have included an application fee check and/or an application fee waiver request with this application. (Attach cashier's check and/or waiver request)

Type of entity (check one)

☐ Sole proprietor ☐ Corporation: ☐ Limited Liability Company: ☐ Nonprofit:
☐ Partnership Corporate number: _____ LLC number: _____ Type: _____
☐ Government entity State incorporated: _____ State registered/filed: _____ ☐ Other: _____

1. Legal name of applicant or provider (as listed with the IRS)

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 number (Attach a legible copy of the recorded/stamped Statement)	Effective date

4. Business address (number, street)	City	County	State	ZIP code (9-digit)

5. Pay-to address (number, street, P.O. box)	City	State	ZIP code (9-digit)

6. Mailing address (number, street, P.O. box)	City	State	ZIP code (9-digit)

For a change of business address, enter location moving <u>from</u>:

7. Previous business address (number, street)	City	State	ZIP code (9-digit)

8. Primary Taxonomy code	Taxonomy code	Taxonomy code

9. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form)	10. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See privacy statement on page 13)

11. California State Board of Pharmacy Permit number (Attach a legible copy)	Expiration date	12. Medicare/Other NPI (see instructions)	13. Seller's Permit number (Attach legible copy)

14. Any local business license numbers/ permits (Attach legible copies)

15. Is your business open and conducting business in compliance with all state and local laws and ordinances regarding business licensing and operations? ☐ Yes ☐ No
If no, please explain: _____
Do you have adequate inventory and staff to meet both your current and your anticipated sales and service requirements? ☐ Yes ☐ No
If no, please explain: _____

16. Does your business have regular and permanently posted business hours? ☐ Yes ☐ No
Business days and hours of operation: Days: _____ Hours: _____
Does your business have permanently attached signage that identifies the name of the business as stated on this application? ☐ Yes ☐ No

17. Do you own the building in which your business is located? ☐ Yes ☐ No
Do you lease the building in which your business is located? ☐ Yes ☐ No
(If you answered yes, attach a copy of the written lease agreement to the application)
If anyone other than you holds an ownership interest in the building, provide the following information about that person(s): (Use additional sheets if necessary.)

Name	Telephone number

Address (number, street)	City	State	ZIP code (9-digit)

18. Do you have the administrative and fiscal foundation to enable your business to survive as a going concern? ☐ Yes ☐ No

19. Do you have the necessary equipment, office supplies, and facilities available to carry out your business, including storing and retrieving such records as are necessary to fully disclose the type and extent of services provided to Medi-Cal beneficiaries? (See CCR, Title 22, Section 51476.) ☐ Yes ☐ No

20. Do you sell, rent, or lease durable medical equipment, incontinence medical supplies and/or supply items? ☐ Yes ☐ No
If yes, do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operation and is readily identifiable? ☐ Yes ☐ No
If no, please explain: _____

Are your equipment and/or supplies:
☐ A. In stock on the premises, or
☐ B. In a warehouse under the applicant's or provider's direct control.
If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code (9-digit)

Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

Name	Telephone number

Address (number, street)	City	State	ZIP code (9-digit)

21. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give the percentage for each of the following business activities for this applicant. Total the percentages at the end of this question, do not leave anything blank, place a (0) if it does not apply to you. Percentages must total 100 percent. (Include licensure information of applicable business activities.) Please see instructions for computing percentages.

A. _____% Prescription Drugs
i. Drug Enforcement Agency Registration Certificate Number: _____
ii. Effective/Expiration Dates (attach a legible copy of the certificate): _____
iii. National Council for Prescription Drug Programs (NCPDP) Number: _____

B. _____% Ambulation Devices (describe): _____

C. _____% Basic Rehabilitation Equipment (describe): _____

D. _____% Specialized Rehabilitation Equipment (describe): _____

E. _____% Basic Wheelchairs, Modifications & Accessories (describe): _____

F. _____% Specialized Wheelchairs, Modifications & Accessories (describe): _____

G. _____% Bathroom Equipment

H. _____% Communication Devices & Speech Generating Devices

I. _____% Diabetic Supplies & Equipment

J. _____% Dialysis Supplies & Equipment

K. _____% Hospital Beds & Accessories; Decubitus Care Equipment; Wound Care; Patient Lifts; Traction

L. _____% Infusion Equipment & Supplies (describe): _____

M. _____% Incontinence Medical Supplies (describe): _____
You must comply with Article 3.7 of the Welfare and Institutions Code.

N. _____% Lactation Supplies & Equipment

O. _____% Non-Surgical Electronic Devices; Pneumatic Compressors & Supplies

P. _____% Orthotic/Prosthetic Appliances (describe): _____

Q. _____% Respiratory Equipment & Supplies (describe): _____

R. _____% Surgical Related Devices

S. _____% Other (describe): _____

_____% **TOTAL**

If your business involves the trade, sale, rental or transfer of upholstered-furniture (including wheelchairs) or bedding please provide a copy of your Bureau of Home Furnishing and Thermal Insulation license. License number: _____

Issuance date: _____ Expiration date: _____

22. Does the applicant or provider provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? ☐ Yes ☐ No

If yes, does the applicant or provider have on staff, either as an employee or independent contractor, or does the applicant or provider have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment? ☐ Yes ☐ No

23. **Proof of Liability Insurance –**
Applicant must attach a copy of their certificate 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

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

25. **Proof of Professional Liability Insurance – Applicant must attach a copy of the certificate of (malpractice) insurance for the Pharmacist-in-charge (PIC) 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

Information About the Pharmacist-in-Charge (PIC) at the Business Location

26. Printed name (last, first, middle)	27. License number (Attach a copy of license)
28. Driver's license or state-issued identification number and state of issuance (Attach a legible copy)	29. Social security number (***Optional***—See Privacy Statement on page 13)

Information About Individual Signing This Application

30. Printed name of provider (last, first, middle)		31. Gender ☐ Male ☐ Female
32. Driver's license or state-issued identification number and state of issuance (Attach a legible copy)	33. Date of birth	34. Social security number (***Optional*** – See Privacy Statement on page 13)

35. **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 CCR, Title 22, Section 51000.30(a)(2)(B).**

Signature of provider	Title

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

36. Notary Public – Please see instructions under number 36 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

37. **Contact Person's Information**

☐ Check here if you are the same person identified in item 30. 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

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the Application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 – 14043.75, the California Code of Regulations, Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. 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. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California 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, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.