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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to:

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

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

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 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.

It is your responsibility to report to the Department of Health Care Services (DHCS) any modifications to information previously submitted within 35 days from the date of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHCS 6209, rev. 01/13) form. However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, a change of business address, or one of the other changes identified in *California Code of Regulations* (CCR), Title 22, Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Medi-Cal Provider Enrollment page at *www.medi-cal.ca.gov*. The Provider Enrollment page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled provider or business, including the option to submit a *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217, rev. 02/08).

Enrollment forms are available at *www.medi-cal.ca.gov* or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our website at *www.medi-cal.ca.gov* and click the "Provider Enrollment" link.

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or submit your question(s) to the address on the previous page or via email at PEDCorr@dhcs.ca.gov.

In order to submit claims electronically, providers must request a submitter number by completing the most recent version of a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, rev. 11/13), available on the Medi-Cal website at *www.medi-cal.ca.gov*, under "Provider Resources", "Forms", and then "Billing."

Provider Enrollment Division

Enclosures (Rev. 04/15)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

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) 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 the 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.

To request consideration for Preferred Provider Status, check the box and include all required documentation pursuant to the provider bulletin dated February 2004. To obtain a copy of this bulletin, you can go to the Medi-Cal Web site, Provider Enrollment link to Preferred Provider Status. Only those complete applications, submitted with all qualifying documentation included, will be processed for preferred provider status.

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.

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 with the Medi-Cal program as a provider with an active provider number. Include the current 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. Indicate the business address applicant is moving from.

"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.

"Clinic-Based Provider' or 'Facility-Based Provider' - If you check this box you must comply with all the enrollment requirements of the applicable provider bulletin. To obtain a copy of the applicable bulletin, you can go to the Medi-Cal Web site, Provider Enrollment link to Provider Bulletins.

"Change of ownership"— check if there is a change of ownership as defined in CCR, Title 22, Section 51000.6. Indicate the effective date in the space provided.

"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 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.

"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. Indicate the effective date in the space provided.

"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 current provider number(s) in the space provided.

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.

"Type of entity"— check the box which identifies 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 box or commercial box is not acceptable.
    a. Check whether the business address is a licensed health facility as defined in Sections 1250,1250.2 and 1250.3 of the Health and Safety Code. Check whether services will be rendered at only the business address indicated. If not, you must submit a separate application for each business address unless you qualify for an exception pursuant to Welfare and Institutions Code Section 14043.15(b)(2). See the 'Facility-Based Provider' bulletin on the "Provider Enrollment Division" page of the Medi-Cal Website (www.medi-cal.ca.gov) for the requirements to qualify for that exception.
    b. Check whether the business address is a licensed primary care clinic as defined by Section 1204(a) of the Health and Safety Code. See the Clinic-Based Provider bulletin on the "Provider Enrollment Division" page of the Medi-Cal Website (www.medi-cal.ca.gov) for the additional requirements.
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. "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 the medical license number(s) of the applicant or provider. Attach a legible copy of the license. List the specialty(ies) and indicate if board certified or eligible.
9. Enter other NPI for the business address indicated in item 4, registered with other carriers including, but not limited to Medicare. Attach copies of CMS/NPPES confirmation for each.
10. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
11. 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).
12. 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 6)
13. Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number. The name and address on the certificate must match the name and address as entered in numbers 1 and 4. Attach a legible copy of the CLIA certificate.
14. Enter the State Laboratory License/Registration number. The name and address on the State Laboratory License/Registration must match the name and address as entered in numbers 1 and 4. Attach a legible copy of the license/registration.
15. 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.
16. Enter the date of birth of the individual named in number 1.
17. Check the gender of the individual named in number 1.
18. Enter any local business license or permit numbers for any city and/or county where you conduct your business activities and attach copies to the application. If this does not apply to you, enter N/A.

19. 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."

20. Enter the requested information. Attach to this application a legible copy(ies) of applicant's or provider's current Certificate of Insurance for Liability Insurance that covers premises and operation for this address. If all services are provided exclusively in a licensed hospital or licensed health facility (as defined in Health and Safety Code, Section 1250), please provide a cover letter with the facility information as proof of liability insurance coverage in accordance with the February 2005 Provider Bulletin regarding Facility-Based Providers.

21. Enter the requested information. Attach a legible copy(ies) of applicant's or provider's current Certificate of Insurance for Professional Liability Insurance (malpractice insurance) to this application.

22. 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.

23. a. Enter information on whether the applicant or provider has hospital privileges. If not please explain why (if arrangements have been made with another physician for admitting patients, please provide his/her name, address, and telephone number). Provide the name(s), address(es), and telephone number(s) of the hospital(s) where current privileges have been granted. If the applicant or provider has privileges at more than one hospital, attach an additional sheet supplying all of the requested information if needed.

    b. Enter information on whether the applicant or provider has had privileges at any hospital(s) that were ever suspended or revoked. If so, provide the name(s), address(es), and telephone number(s) of the hospital(s). Attach an additional sheet supplying all of the requested information for each hospital if needed.

    c. Enter information on whether the applicant or provider has had privileges at any hospital(s) that were voluntarily resigned or otherwise surrendered. If so, provide the name(s), address(es), and telephone number(s) of the hospital(s). Attach an additional sheet supplying all of the requested information for each hospital if needed.

24. Print name of the physician signing the application. An original signature of the individual is required. 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 form.**

25. 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 items(s) that an applicant can readily provide by fax or telephone.

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

- ❒ Driver's license or state-issued identification card
- ❒ TIN verification
- ❒ CLIA Certificate
- ❒ Medical license(s)
- ❒ Fictitious Business Name Statement/Permit
- ❒ State Laboratory License/Registration
- ❒ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ❒ Certificate(s) of Insurance for Liability and Professional Liability Insurance and Workers' Compensation Insurance
- ❒ Local business license(s) or permit(s)
- ❒ Seller's Permit
- ❒ Successor Liability Agreement
- ❒ National Provider Identifier (NPI) verification (CMS/NPPES confirmation)

MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

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

❒ Preferred provider status requested pursuant to Welfare and Institutions Code, Section 14043.26(c). All qualifying documentation and cover letter attached.

- ***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
❒ Facility-Based Provider
❒ Clinic-Based Provider
❒ *Change of ownership (per CCR, Title 22, Section 51000.6)
❒ *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 any items marked with * indicate effective date: ____/___/_____.

❒ 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.
❒ 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.)

* **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 CCR, Title 22, 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 (unincorporated) ❒ Partnership (attach legible copy of agreement) ❒ Government ❒ Nonprofit Corporation—Type of nonprofit: _____
❒ Professional Medical Corporation—corporate number: _____ ❒ 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 Permit number

Effective date / /

(Attach a legible copy of the Fictitious Business Name Permit issued by the Medical Board.)

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

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).

b. If you are applying as a **clinic-based provider**, complete this section:
This address is a licensed primary care clinic. ❒ Yes ❒ No
If yes, check **ALL** options that apply:
❒ All services are provided at this primary care clinic location only
❒ At acute care facilities when following patients for continuity of care
❒ At hospitals when providing "on call" coverage for Medi-Cal patients
❒ As part of a graduate medical program

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

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

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

8. Medical license number (attach a legible copy) | List specialty(ies) | YES NO Board certified ❒ ❒ Board eligible ❒ ❒ | 9. Medicare/Other NPI (see instructions)

10. Primary Taxonomy Code | Taxonomy Code | Taxonomy Code

11. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form.)	12. Social security number—if Sole Proprietor not using a TIN, you must disclose this number (See Privacy Statement on page 6.)
__ __ — __ __ __ __ __ __ __	__ __ __ — __ __ — __ __ __ __
13. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)	14. State Laboratory License/Registration number (attach a legible copy)

15. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	16. Date of birth / /	17. Gender ❒ Male ❒ Female
18. Any local business license numbers/permits (attach legible copies)	19. Seller's Permit number (attach a legible copy or proof of exemption)	

20. **Proof of Liability Insurance**—Applicant must attach a copy of their certificate of insurance for this 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

❒ Facility-based provider. Attach cover letter.

21. **Proof of Professional Liability Insurance or equivalent coverage**—Applicant must attach a copy of their certificate of (malpractice) insurance policy or coverage 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

22. 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:

23. **Hospital Privileges**

a. Do you have current hospital privileges? ❒ Yes ❒ No
If no, please explain: _____
If yes, please enter the following (attach additional sheet(s) if needed):

Name of hospital		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

b. Have your hospital privileges ever been suspended or revoked? ❒ Yes ❒ No
If yes, please enter the following (attach additional sheet(s) if needed):

Name of hospital		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

c. Have you ever voluntarily resigned or otherwise surrendered your hospital privileges? ❒ Yes ❒ No
If yes, please enter the following (attach additional sheet(s) if needed):

Name of hospital		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

24. **Provider Agreement**

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments are true, accurate, and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to California Code of Regulations, Title 22, Section 51000.30(a)(2)(B).

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Care Services ("DHCS"), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider in the Medi-Cal program.

I agree to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services ("Secretary"). I further agree to provide if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Physician from participation in the Medi-Cal program. Physician will be reimbursed for reasonable copy costs as determined by DHCS, AG and/or Secretary.

I also agree that DHCS, AG and/or Secretary may make unannounced visits to Physician, at any of Physician's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS, AG and/or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of physician from participation in the Medi-Cal program.

Printed name of physician (last) (first) (middle)

Signature of the physician

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

25. **Contact Person's Information**

❒ Check here if you are the same person identified in item 24. 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 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.