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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Clinical Laboratory Provider Applicant:

Thank you for your 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. Current Medi-Cal providers will be required to submit both the NPI and any Medi-Cal provider numbers issued previously on any application forms submitted to the Department of Health Care Services (DHCS). Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation letter 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.

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, 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), Section 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.

The moratorium on the enrollment of clinical laboratory providers expired October 3, 2015. This letter provides information for clinical laboratory applicants applying for enrollment in the Medi-Cal Fee-for-Service Program during the six-month period following the expiration of the moratorium.

State Medicaid Agencies are required to collect fingerprints and conduct criminal background checks from applicants or providers screened at the "high" categorical risk level. (42 CFR §§ 424.518, 455.434, and 455.450)

Title 42, CFR, Section 455.450(e)(2) and *Welfare and Institutions Code* (W&I Code), Section 14043.38(b)(4) specify that a provider that would have been prevented from applying for enrollment due to a moratorium that has been lifted in the past six months, be screened at the "high" categorical risk level.

A “high” risk screening requires a provider or applicant to submit proof that fingerprints for all the required individuals have been submitted to an authorized State Identification Bureau (Bureau of Criminal Information and Analysis, Department of Justice [DOJ] in California). Providers and applicants must attach a copy of a prefilled DOJ *Request for Live Scan Service* (BCIA 8016) form for each required individual with their application, date stamped and show verification that all fees have been paid by either a “PAID” stamp from the public Live Scan operator or a receipt of payment.

If you would have met one of the exemptions listed below, you do not need to be screened as “high” risk but you must submit a cover letter with your application advising which exemption you meet and include any necessary supporting documentation.

1. A clinical laboratory owned and operated by a physician or physician group so long as the physician or physician group only performs Provider-Performed Microscopy Procedures (PPMP) and/or waived clinical laboratory tests or examinations;
2. Current Medi-Cal enrolled clinical laboratory providers that have at least six actively enrolled locations, and seek to add a new business location, so long as the provider does not add new business activities, categories of service or billing codes other than those approved for enrollment at its existing locations; this exemption is only applicable to clinical laboratory providers who meet this criteria and all six locations are continuously and actively enrolled and in good standing with Medi-Cal, from February 12, 2007, through the date of application;
3. A clinical laboratory that is owned and operated by a general acute care hospital or psychiatric hospital licensed pursuant to *Health and Safety Code* (H&S Code), Section 1250, et seq.;
4. A clinical laboratory that is owned and operated by a clinic licensed pursuant to H&S Code, Section 1200, et seq.;
5. A public health laboratory as defined in Business and Professions Code, Section 1206(a) and certified pursuant to H&S Code Section 101160;
6. The purchase of an existing clinical laboratory that is currently enrolled in the Medi-Cal program as a clinical laboratory, whether it constitutes a change of ownership or not; unless it is being sold by a laboratory provider who has expanded their location(s) and/or services, under Exemption #13;
7. An out-of-state clinical laboratory requesting enrollment for the sole purpose of providing services to a Medi-Cal beneficiary on an emergency basis, in accordance with the *California Code of Regulations* (CCR), Title 22, Section 51006;
8. The change of location of an existing clinical laboratory that is currently enrolled in the Medi-Cal program as a clinical laboratory, so long as it neither constitutes a change of ownership nor involves the change or addition of specialty codes;
9. A clinical laboratory that only seeks reimbursement for Medicare cost sharing amounts;
10. Currently enrolled clinical laboratory providers that DHCS requires to submit an application for continued enrollment pursuant to CCR, Title 22, Section 51000.55;
11. A clinical laboratory that performs a test or examination that is a Medi-Cal covered benefit and the clinical laboratory is the only Clinical Laboratory Improvement Amendments (CLIA) approved clinical laboratory in the United States to perform that test or examination;
12. Applicants whose sole business is, and continues to be throughout the existence of this moratorium, a clinical laboratory performing only anatomic pathology services that has a laboratory director certified in anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology;

13. A clinical laboratory that is owned and operated by a professional medical corporation or partnership of professional medical corporations, comprised of physicians that are certified by the American Board of Pathology or the American Osteopathic Board of Pathology in clinical or anatomic pathology, who can provide evidence of a current contract to provide pathology services at a licensed and Medi-Cal certified acute care hospital in California, that currently is enrolled as a clinical laboratory provider and seeks to obtain a provider number for an additional location that will also perform clinical laboratory services, whether anatomic or clinical pathology services, and/or seeks to add new business activities, categories of service or billing codes other than those approved at its initial enrollment at its current business location. Exemption #13 only applies to those clinical lab providers who remain under the same common ownership and directorship, as defined above, for all of their business locations, throughout the period of this Moratorium;
14. A clinical laboratory that performs a test or examination that is a Medi-Cal covered benefit and, as of the date of application denial or approval, no Medi-Cal provider offers a test or examination that fills the same functional role. Multiple applications from providers asserting this exception will be granted or denied in the order they were submitted;
15. A clinical laboratory, that is licensed by the California Department of Public Health (CDPH) as a clinical laboratory that will be providing services **exclusively** to California Medi-Cal beneficiaries placed through the Interstate Compact Placement of Children program (ICPC) in an out-of-state residential care facility approved by the California Department of Social Services, and for whom the residential care facility has provided a "letter of certification" that the **facility is using** the laboratory to provide services for ICPC placed Medi-Cal beneficiaries.
16. A CLIA approved clinical laboratory that, as of the date of the application, performs a test or examination that is not performed or available through an existing Medi-Cal provider. Reimbursement shall be limited to the tests and examinations that form the basis of this exemption and that have been prior authorized by the Department.

If DHCS determines that you do not meet an exemption or if you do not want to go through an exemption review, you are required to be screened at the "high" categorical risk level and submit fingerprints for a criminal background check.

Failure to submit fingerprints for a criminal background check when required will result in the denial of the application package. (42 CFR § 455.416; W&I Code § 14043.26[f][4][E])

Additional information about the Medi-Cal requirements for submitting fingerprints is available in the "Medi-Cal Requirement to Submit Fingerprints for a Criminal Background Check" provider bulletin.

If you wish to enroll as a Medi-Cal clinical laboratory provider, please complete a new application package consisting of a *Medi-Cal Provider Application* (DHCS 6204, Rev. 2/17), a *Medi-Cal Provider Agreement* (DHCS 6208, Rev. 2/17), a *Medi-Cal Disclosure Statement* (DHCS 6207, Rev. 2/17) and any required attachments.

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 may be reported on a *Medi-Cal Supplemental Changes* form (DHCS 6209, Rev. 10/16). However, 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 the CCR, Title 22, Section 51000.30, subsections (a) through (b), you must complete a new application package.

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 clinical laboratory, including the option to submit a *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217, Rev. 2/08).

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, form completion 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, in writing, to the address on the front page or via email at PEDCorr@dhcs.ca.gov.

In order to submit claims electronically, providers must request a submitter number by completing a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, Rev. 3/17), available on the Medi-Cal website at www.medi-cal.ca.gov, under “Provider Resources”, “Forms”, then “Billing”.

A submitter billing number for an existing clinical laboratory provider is not transferable. A new DHCS 6153 form must be submitted each time a new enrolled location is approved.

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. 6/17)

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 (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. 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) has been issued by the IRS.

"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 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 or transfer 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.

Medi-Cal Application Fee – check all that apply.

Check the box labeled "I am requesting enrollment as an individual …" if you are requesting enrollment as an individual non-physician practitioner. These providers are exempt from paying the application 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.

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 8, item 4 of the application, and under the legal name listed on page 8, 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 8, item 4 of the application, and under the legal name listed on page 8, 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 8, item 4 of the application, and under the legal name listed on page 8, 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. Physician provider groups are to submit a legible copy of the Fictitious Business Name Permit issued by the Medical Board of California.
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.
    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 W&I Code Section 14043.15(b)(2). See the 'Facility-Based Provider' bulletin on the Medi-Cal Web site (www.medi-cal.ca.gov) for the requirements to qualify for that exception.
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 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.

9. Enter the provider type. See list in CCR, Title 22, Section 51051.
10. Enter any additional 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. Providers not eligible to receive an NPI (atypical providers) should submit a Medicare billing number.
11. Enter each taxonomy code(s) associated with your NPI. Attach additional sheets if needed.
12. 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).
13. 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 10)
14. Nurse Practitioners only—enter the duration of the nurse practitioner training program and the school at which the nurse practitioner training program was completed.
15. Nurse Practitioners only—enter clinical and didactic training or equivalent experience completed. Attach a legible copy.
16. Enter the Clinical Laboratory Improvement Amendment (CLIA) Certificate number. Attach a legible copy of the CLIA Certificate.
17. Enter the State Laboratory License/Registration number. If this does not apply to you, enter “N/A.” Attach a legible copy of the license/registration.
18. Enter the driver’s license or state-issued identification number and state of issuance of any 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.
19. 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 and insurance agent’s telephone number. You must attach a copy of your certificate of insurance for the identified business address to the application.
20. 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 and insurance agent’s telephone number. You must attach a copy of your certificate of insurance to the application.
21. 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.
22. Enter the date of birth of the individual named in number 1, if applicable. If not applicable, enter N/A.
23. Check the gender of the individual named in number 1, if applicable. If not applicable, enter N/A.
24. 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.
25. 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.

26. “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.
27. Check the gender of the individual named in number 26.
28. Enter the driver’s license or state-issued identification number and state of issuance of the individual named in number 26. Attach a legible copy to the application.
29. Enter the date of birth of the individual named in number 26.
30. Enter the social security number of the individual named in number 26. Provision of the social security number is optional (See Privacy Statement on page 10).
31. An original signature of the individual named in number 26 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. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this application.**
32. 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.
33. 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
- ☐ Driver's license or state-issued identification card
- ☐ TIN verification
- ☐ CLIA Certificate
- ☐ License, certification, or other approval
- ☐ Fictitious Business Name Statement or Fictitious Name Permit
- ☐ State Laboratory License/Registration
- ☐ Signed Medi-Cal Provider Agreement (DHCS 6208)
- ☐ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ☐ Certificate of Liability Insurance
- ☐ Certificate of Professional Liability Insurance
- ☐ Proof of Workers' Compensation Insurance
- ☐ Successor Liability Agreement
- ☐ National Provider Identifier (NPI) verification (CMS/NPPES verification)
- ☐ Clinical and didactic training or equivalent experience completed (Nurse Practitioners only)

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.
- 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
☐ Facility-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 or transfer 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.

***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: _____

Medi-Cal Application Fee (check all that apply)

☐ I am requesting enrollment as an individual non-physician practitioner.
☐ 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/Permit number (Attach a legible copy of the recorded/stamped Statement/Permit)			Effective date
4. Business address (number, street)	City	County	State	ZIP code (9-digit)

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)	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 from:

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

8. License number (Attach legible copy)	License effective date	License expiration date	9. Provider type	10. Medicare/Other NPI (see instructions)

11. Primary Taxonomy code	Taxonomy code	Taxonomy code

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 10)

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

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)

19. **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 (mm/dd/yyyy)
Insurance agent's name		Telephone number

20. **Proof of Professional Liability Insurance – Applicant must attach a copy of their certificate of (malpractice) insurance for the business address**

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date (mm/dd/yyyy)
Insurance agent's name		Telephone number

21. 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 below:

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

Information About Individual Signing This Application

26. Printed name of applicant or provider or person signing the application on behalf of the applicant or provider	27. Gender ☐ 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 on page 10)

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

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

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

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.