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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Applicant:

****Effective November 4, 2016, a complete Rendering Provider application includes the Medi-Cal Rendering Provider/Group/Affiliation/Disaffiliation Form (DHCS 4029). This form must be submitted with the Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers.****

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 *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. 01/17)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED/DENTAL PROVIDERS

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 question, 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 rendering 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. Additional information can be found on the following Medi-Cal Website (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

Omission of any information on this form, or the failure to provide required documentation or sign any of these documents may result in denial of the application as provided 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.

To request consideration for Preferred Provider Status, check the box and include all required documentation pursuant to the Preferred Provider Bulletin dated February 2004, which is available on the "Provider Enrollment Division" (PED) page of the Medi-Cal Website (www.medi-cal.ca.gov). Only those complete applications submitted with all qualifying documentation included will be processed with a preferred provider status.

Action requested (check all that apply). Enter the date you are completing the application.

"New rendering physician/allied/dental provider"—The applicant is not currently enrolled with the Medi-Cal program as a provider with an active provider number.

National Provider Identifier—enter your NPI. If the individual identified in item 1 has more than one, enter the NPI you wish to use for enrollment as a rendering provider.

Provider Type: Check the appropriate provider type box for which you are applying to render services for the Medi-Cal program.

1. "Legal name"—enter the name listed with the Internal Revenue Service (IRS).
2. Enter the date of birth of the individual named in number 1.
3. Enter the gender of the individual named in number 1.
4. "Residence address"—enter the residence address of the individual listed in number 1.
5. "Mailing address"—enter the address where correspondence may be sent to the individual listed in number 1.
6. Enter the social security number of the individual named in number 1. (This field is mandatory-see Privacy Statement on Page 5)
7. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
8. Enter the license, certificate number, or other permit or approval to provide health care, of the applicant. Attach a legible copy of the license, certificate, permit, or approval. Enter the effective date of the license, certificate number, or other permit or approval. Enter the expiration date of the license, certificate number, or other permit or approval. If a physician or dentist, list the specialty(ies) and indicate if board-certified or board-eligible.
9. "Business address"—enter the actual business location including the street number and name, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
10. "Business telephone number"—enter 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.
11. "Contact person"—enter the name of the person who can be contacted regarding the application package.
12. "Contact telephone number"—enter the phone number of the contact person.
13. "Contact e-mail address"—enter the e-mail address of the contact person.
14. "Provider number of Group being joined"—enter the NPI or Denti-Cal provider number of the Medi-Cal Group Provider that the individual named in number 1 is joining.

15. "Proof of professional liability insurance"—enter the name of the insurance company, insurance policy number, date policy issued, expiration date of policy, insurance agent's name, telephone number of the insurance agent, fax number of the insurance agent and email address of the insurance agent. You must also attach a copy of your certificate of insurance to the application.

Disclosure Information

1. Check the appropriate boxes and provide the date of conviction if applicable.
2. Check the appropriate boxes and provide the date of final judgment if applicable.
3. Check the appropriate boxes and provide the date of settlement if applicable.
4. Check the appropriate box and list all provider numbers, if appropriate, as well as the state(s) and name(s) applicant or provider used when participating in another state Medicaid program and all applicable provider numbers. If you cannot provide the numbers, please explain.
5. Check the appropriate box and, if applicable, provide Medicare, Medicaid, and/or Medi-Cal NPIs or provider number(s), the effective date(s) of suspension(s), and date(s) of reinstatement.
6. Check the appropriate box and, if applicable, list the state(s) where applicant's or provider's license, certificate, or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
7. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach a written confirmation from the licensing authority that professional privileges have been restored.
8. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was disciplined by a licensing authority, actions taken, and the effective dates of those actions. Attach a written confirmation from the licensing authority decision(s) including any terms and conditions for each decision.
9. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid, and all other federal and state health health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). Submit copies of all documents pertaining to the arrangement(s) including terms and conditions. If not applicable, check N/A box.
10. To assist in the timely processing of the application package, enter the name, title/position, email 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.

Provider Agreement

Print name of the applicant 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 application.**

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

- ☐ Driver's license or state-issued identification card
- ☐ License certificate
- ☐ Verification of reinstatement
- ☐ Written confirmation from licensing authority that your professional privileges have been restored.
- ☐ Copies of payment arrangement documents
- ☐ Notary Public Certificate of acknowledgement
- ☐ Certificate of insurance (malpractice)
- ☐ Drug Enforcement Agency (DEA) certificate
- ☐ Anesthesia Permit
- ☐ Conscious Sedation Permit
- ☐ National Provider Identifier verification (CMS/NPPES confirmation)

MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED/DENTAL PROVIDERS

Important:

- Read all instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:
  Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997412
  Sacramento, CA 95899-7412
  (916) 323-1945

  For Denti-Cal return completed forms to:
  Department of Health Care Services
  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

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

FOR STATE USE ONLY

Do not use staples on this form or on any attachments. Do not use correction fluid or tape.
Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check[✓] all that apply)	National Provider Identifier (NPI)	Date
☐ New rendering physician/allied/dental provider		/ /

Provider Type (check one)

☐ Chiropractor ☐ Physician
☐ Audiologist ☐ Dentist ☐ Podiatrist ☐ Registered Dental Hygienist Alternative Practice
☐ Certified Nurse Midwife ☐ Optometrist ☐ Prosthetist ☐ Other: _____
☐ Certified Registered Nurse Anesthetist ☐ Orthotist ☐ Psychologist

1. Legal name of applicant	2. Date of birth	3. Gender
	/ /	

4. Residence address (number, street)	City	State	Nine-digit ZIP code
5. Mailing address (number, street)	City	State	Nine-digit ZIP code

6. Social security number (required)	7. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

8. Professional license/certificate/permit number (attach legible copy)	License/certificate/permit effective date	License/certificate/permit expiration date	List specialty(ies)—Physicians and dentists only	Yes	No
	/ /	/ /	Board-certified	☐	☐
			Board-eligible	☐	☐

9. Business address (office/hospital) (number, street)	City	County	State	Nine-digit ZIP code

10. Business telephone number	11. Contact person's name	12. Contact person's telephone number	13. Contact person's e-mail address
( )		( )	

14. Provider number (NPI or Denti-Cal Provider Number as applicable) of group being joined

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

Name of Insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration Date of policy (mm/dd/yyyy)
	/ /	/ /

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

DISCLOSURE INFORMATION

Respond to the following questions:

1. ***Within ten years of the date of this statement***, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____

2. ***Within ten years of the date of this statement,*** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No

   If yes, provide the date of final judgment (mm/dd/yyyy): _____

3. ***Within ten years of the date of this statement,*** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No

   If yes, provide the date of the settlement (mm/dd/yyyy): _____

4. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No

If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	NPI AND/OR PROVIDER NUMBER(S)

5. Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No

If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	NPI AND/OR PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal ☐ Medicaid ☐ Medicare		/ / / / / /	/ / / / / /
☐ Medi-Cal ☐ Medicaid ☐ Medicare		/ / / / / /	/ / / / / /

6. Has the individual license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been suspended or revoked? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)
		/ /
		/ /

7. Have you, the applicant/provider, ***ever*** lost or surrendered your license, certificate, or other approval to provide health care while a disciplinary hearing was pending? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)
		/ /
		/ /

8. Has the license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority decision(s) including any terms and conditions for each decision and provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)
		/ /
		/ /

9. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See CCR, Title 22, Section 51000.50(a)(6). ☐ N/A

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
$		/ /	/ /
$		/ /	/ /

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 is true, accurate, and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to CCR, 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. 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 Applicant/Provider from participation in the Medi-Cal program. Applicant/Provider will be reimbursed for reasonable copy costs as determined by DHCS or AG.

I also agree that DHCS and/or AG may make unannounced visits to Applicant/Provider, at any of Applicant's/Provider'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 or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

Printed legal name of applicant (last) (first) (middle)

Original signature of applicant

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

Notary Public:

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 notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

10. Contact Person's Information

☐ Check here if you are the same person identified in item 1. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (Last) (First) (Middle)

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 or contact Denti-Cal at (800) 423-0507.