SUCCESSOR LIABILITY WITH JOINT AND SEVERAL LIABILITY AGREEMENT

This section is to be signed and dated by provider transferor and transferee applicant:

____ and ____
(legal name of provider transferor on file with IRS) (legal name of transferee applicant on file with IRS)

acknowledge that the Medi-Cal Provider Agreement between the provider transferor and the Department of Health Care Services (DHCS) for the business operations at

____
(street address, city and nine-digit zip code of location being transferred)

is being assigned to the transferee applicant effective _______________________.
(effective date of transfer)

The provider transferor and transferee applicant acknowledge and agree that they both will be jointly and severally liable for all debts arising from the Medi-Cal Provider Agreement applicable to the location indicated below, from the date of this agreement until the transferee applicant's application is either approved or denied. Both transferor and transferee agree not to submit any claims to DHCS using an NPI unless that NPI is appropriately registered with the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Both transferor and transferee agree that submission of an NPI to DHCS as part of an application to use that NPI for billing services constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Both transferor and transferee agree that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of California Code of Regulations, Title 22, Section 51000.40.

FOR PROVIDER TRANSFEROR

Signed this ______________________ day of _____________________, ___________
(day of month) (month) (year)

in ____, California.
(name of county where signed)

____ ____________________
(signature of provider transferor) (date)

____
(current NPI or Denti-Cal provider number of provider transferor)

____
("Fictitious Business" name of provider transferor, if applicable)

FOR TRANSFEREE APPLICANT

Signed this ______________________ day of _____________________, ____________
(day of month) (month) (year)

in ____, California.
(name of county where signed)

____ _______________
(signature of transferee applicant) (date)

____
(current NPI or Denti-Cal provider number of transferee applicant, if applicable)

____
("Fictitious Business" name of transferee applicant, if applicable)

I ____, declare under penalty of perjury under the
(name of transferee applicant)

laws of the State of California that I meet all of the requirements to be a Medi-Cal provider.

Executed at ______________________________, _______________________ on __________________
(city) (state) (date)

Notary Public

Notarization is required. The Certificate of Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

This letter should be postmarked no later than five (5) days after the occurrence of the circumstance listed in California Code of Regulations (CCR), Title 22, Section 51000.30(b). The transferee applicant must submit a complete application package to be received by the Department within 35 days of the occurrence of a circumstance listed in (b)(1), (b)(2), (b)(6), or (b)(7). This is required per CCR, Title 22, Section 51000.30(b).