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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Hospital-Based Physician Applicant:

Thank you for your interest in participating as a provider in the Medi-Cal program. This *Medi-Cal Hospital-Based Physician Application/Disclosure Statement/Agreement* (DHCS 9095, new 7/08), is solely for use by doctors of medicine and osteopathic physicians applying for enrollment or continued enrollment pursuant to *Welfare and Institutions Code* (W&I Code), Section 14043.26(e). In order to use this application form, you must meet **all** of the following conditions:

- Your medical practice is based at a general acute care hospital, a rural general acute care hospital or an acute psychiatric hospital as defined in the Health and Safety Code, Section 1250, subdivisions (a) and (b).
- Your license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California is current, unrevoked and unsuspended and the same license has not had a revocation stayed, has not been placed on probation or had any other limitation placed on it.
- You do not have an adverse entry in the Healthcare Integrity and Protection Databank (HIPDB).

PLEASE NOTE: The attached application form is not appropriate for enrollment of **groups** of hospital-based physicians. Hospital-based physician groups must use the *Medi-Cal Provider Group Application (DHCS 6203, rev. 01/13)* to enroll the group entity and indicate that they are applying as a Facility-Based Provider Group. A *Medi-Cal Rendering Provider Application/Disclosure Statement/ Agreement (DHCS 6216, rev. 07/14)* must also be submitted for each rendering provider in the group. For additional information on application requirements for a facility-based group, please refer to the provider bulletin entitled, “Requirements and Procedures for Enrollment as a Facility-Based Provider” at *www.medi-cal.ca.gov*.

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 carefully read all the instructions included in the application package and complete each item requested. You will receive notification of receipt of your application package within 15 days of the Department of Health Care Services (DHCS) receiving it.

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.

It is your responsibility to report to DHCS any changes in 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, full application package when 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 above or via email at PEDCorr@dhcs.ca.gov. In order to submit claims electronically, providers must request a submitter number by completing the most current version of 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.” If you have any questions about obtaining an electronic billing submitter number, call TSC at 1-800-541-5555 and select the option for Computer Media Claims.

Provider Enrollment Division

Enclosures (Rev. 04/15)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL HOSPITAL- BASED PHYSICIAN APPLICATION/DISCLOSURE STATEMENT/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 question, boxes, lines, etc. blank. Enter N/A if not applicable to you.

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.

Eligibility to Use this Form

This "Medi-Cal Hospital-Based Physician Application/Disclosure Statement/Agreement" is to be used solely by physicians applying for enrollment or continued enrollment pursuant to Welfare and Institutions Code, Section 14043.26(e). In order to use this specific application form, you, the physician applicant must meet all of the following criteria:

- Your medical practice is based at a general acute care hospital, a rural general acute care hospital or an acute psychiatric hospital as defined in the Health and Safety Code, Section 1250, subdivisions (a) and (b).
- Your license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California is current, unrevoked and unsuspended and the same license has not had a revocation stayed, has not been placed on probation or had any other limitation placed on it.
- You, the applicant, do not have an adverse entry in the Healthcare Integrity and Protection Databank (HIPDB).

Unless all of the above statements apply to you, you are not eligible to use the "Medi-Cal Hospital-Based Physician Application/Disclosure Statement/Agreement" (DHCS 9095) and instead you must submit a "Medi-Cal Physician Application/Agreement" (DHCS 6210) and a "Medi-Cal Disclosure Statement" (DHCS 6207).

Instructions

Provider Number— submit the current NPI for the business address you provide in Section 1, item 4.

Enter the date you are completing the application.

Enrollment action requested — check all that apply.

"New provider"— check if not currently enrolled with the Medi-Cal program as a provider with an active provider number.

"Changing from non-hospital based to hospital-based"— check if currently enrolled in the Medi-Cal program and requesting to relocate to a new business address at a hospital-based location and are also vacating the old location. Indicate the business address you are moving from in Section 1, item 7.

"New Taxpayer ID number"— check if a new Taxpayer Identification Number (TIN) was issued by the IRS.

"Change of ownership"— check if there is a change of ownership as defined in Title 22, CCR, 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 Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment. Indicate the effective date in the space provided.

"Sale of assets (50 percent or more)"— check if 50 percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred. Indicate the effective date 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 Title 22, CCR, Section 51000.51.

"Continued enrollment"— check if currently enrolled as a Medi-Cal provider and you have been requested by the DHCS to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from DHCS, pursuant to Title 22, CCR, Section 51000.55.

Check the box labeled, "A provider agreement may not be transferred…" if you intend to enter into successor liability. Please see the bulletin, "Requirements and Procedures for Successor Liability" published in the December 2005 *Medi-Cal Update* and available at: http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/PEB_Dec05_7183.doc.

I. Professional and Established Place of Business Information

"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 of applicant or provider"—enter the name listed with the Internal Revenue Service (IRS).
2. "Business name"—enter the business name if different than the legal name indicated in item 1.
3. "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.
4. "Business address"—enter 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.
5. "Current 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. "Current 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"— enter previous business location, if changing from non-hospital based to hospital-based.
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 any 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 an 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 7)
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. "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, fax number and email address of the insurance agent. You must also attach a copy of your certificate of insurance to the application.

II. Disclosure Information

If any of the following statements are true, leave "Section II Disclosure Information" blank and instead, you must submit a complete Medi-Cal Disclosure Statement (DHCS 6207) with this application:

- **Another person besides you, the applicant, has 5% or greater ownership or control interest in your business.**
- **Another entity, besides yours, has 5% or greater ownership or control interest in your business.**
- **You have 5% or greater direct or indirect ownership in any subcontractor and/or any other healthcare business(es).**

The Medi-Cal Disclosure Statement includes detailed instructions on calculating ownership and control interest percentages for individuals, entities and subcontractors. Applicants/providers are responsible for determining whether they are eligible to use this form alone or must instead submit a completed Medi-Cal Disclosure Statement.

1. "Residence address"— enter the applicant/provider's residence address.
2. Enter the applicant/provider's current driver's license or state-issued identification number and state of issuance. 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.
3. Enter the applicant/provider's date of birth.
4. Enter the applicant/provider's gender.

5. Check the appropriate boxes and provide the date of conviction if applicable.
6. Check the appropriate boxes and provide the date of final judgment if applicable.
7. Check the appropriate boxes and provide the date of settlement if applicable.
8. 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.
9. Check the appropriate box and, if applicable, provide the effective date(s) of suspension(s), date(s) of reinstatement, and Medi-Cal, Medicare and/or Medicaid NPIs or provider number(s). Attach a copy of reinstatement verification.
10. 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.
11. 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.
12. Check the appropriate box and, if applicable, list the requested information. Attach copies of licensing authority decisions including terms and conditions for each decision.
13. 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 arrangement(s) including terms and conditions. If not applicable, check N/A box.

III. Provider Agreement

1. Print name of the applicant signing the application.
2. An original signature of the individual is required. Include the city, state, and the date where and when the application was signed. See Title 22, California Code of Regulations, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this form.
3. 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 contact information may result in a delay of your enrollment if Provider Enrollment staff are not able to contact you for any missing items needed to build your provider file.

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

- ☐ National Provider Identifier verification (CMS/NPPES confirmation)
- ☐ Fictitious Business Name Statement/Permit
- ☐ Medical license
- ☐ TIN verification
- ☐ Driver's license or state-issued identification card
- ☐ CLIA Certificate
- ☐ State Laboratory License/Registration
- ☐ Certificate of Insurance Professional Liability Insurance
- ☐ Verification of reinstatement
- ☐ Written confirmation from licensing authority that your professional privileges have been restored
- ☐ Licensing authority disciplinary decision(s) including terms and conditions
- ☐ Copies of payment arrangement documents
- ☐ Medi-Cal Disclosure Statement (DHCS 6207—required for applicants/providers as specified in the instructions for Section II above.)
- ☐ Copy of Medi-Cal/Medicaid or Medicare reinstatement verification (if applicable)

MEDI-CAL HOSPITAL-BASED PHYSICIAN APPLICATION/DISCLOSURE STATEMENT/AGREEMENT

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 leave any questions, boxes, lines, etc. blank.
Enter N/A if not applicable to you.

FOR STATE USE ONLY

Check each box, as applicable. Unless all of the following statements apply to you, you are not eligible to use this application form and must submit a complete application package.

☐ My practice is based at a general acute care hospital, rural general acute care hospital, or acute psychiatric hospital as defined in Health and Safety Code Section 1250, subdivisions (a) and (b).

☐ My license as a physician and surgeon issued by the Medical Board of California or Osteopathic Medical Board of California is current, unrevoked and unsuspended. My license has not had a revocation stayed and I am not on probation nor do I have any other limitation placed on my license.

☐ I do not have an adverse entry in the Healthcare Integrity and Protection Databank (HIPDB).

Provider Number (NPI): _____ (attach copy of CMS/NPPES confirmation)

Date:

Enrollment action requested (check[✓] all that apply)

☐ New provider

☐ Changing from non-hospital based to hospital-based

☐ New Taxpayer ID number

☐ *Change of ownership (per Title 22, CCR, Section 51000.6)

☐ *Cumulative change of 50 percent or more in person(s) with ownership or control interest.

☐ *Sale of assets (50 percent or more, per Title 22, CCR, Section 51000.30)

For any items marked with * indicate effective date:____/____/_____.

☐ I intend to use my 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 Title 22, CCR, 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 Title 22, CCR, 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 Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint and Several Liability."

Indicate the change of ownership date: ____/____/_____

I. PROFESSIONAL AND ESTABLISHED PLACE OF BUSINESS INFORMATION

Type of entity

☐ Sole Proprietor (unincorporated) ☐ Partnership **(Attach legible copy of agreement)** ☐ 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 your Medical Licensing Board)

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

Check the option that applies:

☐ All services are provided at this location which is a general acute care hospital, rural general acute care hospital, or acute psychiatric hospital.

☐ I am requesting an exemption pursuant to W&I Code, Section 14043.15(b)(2). (Attach a list of all business addresses where provider renders services.)

5. Current Pay-to address (P.O. Box number or address number, street, suite number as applicable)	City	State	Nine-digit ZIP code

6. Current Mailing address (P.O. Box number or address number, street, suite number as applicable)	City	State	Nine-digit ZIP code

If changing from a non-hospital based practice to a hospital-based practice, enter previous location you are moving from.

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

8. Medical license number (attach legible copy)	List specialty(ies)	Yes	No	9. Medicare/other NPI (see page two of instructions)
	Board-certified	☐	☐	
	Board-eligible	☐	☐	

10. Primary taxonomy code	Taxonomy code	Taxonomy code

11. Taxpayer Identification Number (TIN) (Attach 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 7)
___ ___ — ___ ___ ___ ___ ___ ___ ___	___ ___ ___ — ___ ___ — ___ ___ ___ ___
13. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)	14. State Laboratory License/Registration Number (attach a legible copy)

15. **Proof of Professional Liability Insurance**

Name of Insurance company (Attach a copy of the certificate of (malpractice) insurance to this application.)

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
( )	( )	

II. DISCLOSURE INFORMATION

Answer each Statement "Yes" or "No", as applicable. If you should need to answer "Yes" to any of these three statements, you must submit a complete Medi-Cal Disclosure Statement (DHCS 6207) with this application, so you may proceed directly to Section III of this application form.

☐Yes ☐No Another person besides myself, has 5% or greater ownership or control interest in my medical business.

☐Yes ☐No Another entity besides my own, has 5% or greater ownership or control interest in my medical business.

☐Yes ☐No I, the applicant/provider, have 5% or greater direct or indirect ownership in a subcontractor and/or other healthcare business(es).

1. Residential address (number, street) (city) (state) (Nine-digit ZIP code)

2. Driver's license or state-issued identification number and state of issuance (attach legible copy)	3. Date of birth	4. Gender
	/ /	☐ Male ☐ Female

5. ***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): / /

6. ***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): / /

7. ***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): / /

8. 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)

9. 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		/ / / / / /	/ / / / / /

10. 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)
		/ /
		/ /

11. 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)
		/ /
		/ /

12. 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, include copies of 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)
		/ /
		/ /

13. 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 California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐ N/A

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

III. 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 Title 22, California Code of Regulations, 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.

1. Printed legal name of applicant (last) (first) (middle) (Jr., Sr., etc.)

2. Original signature of applicant

Executed at: _____ (city), _____ (state) on ____/____/____ (date)

3. 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) (gender) ☐ male ☐ female

Title/position	E-mail address	Telephone number ( )

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application 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) and Title 22, California Code of Regulations, Section 51536. 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. 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.