



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



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, Rev. 5/17), 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* (H&S 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. 2/17) 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. 5/17) 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](http://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, CA 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 Centers for Medicare & Medicaid Services (CMS)/National Plan and Provider Enumeration System (NPES) 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* form, (DHCS 6209, Rev. 10/16). 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](http://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. 5/17).

Enrollment forms are available at [www.medi-cal.ca.gov](http://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](http://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](mailto: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. 3/17), available on the Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) under "References", "Forms", and then "Billing." If you have any questions about obtaining an electronic billing submitter number, call the TSC at 1-800-541-5555 and select the option for Computer Media Claims (CMC).

Provider Enrollment Division

Enclosures

(Rev. 8/17)

**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 questions, 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 signature in ink on 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 a copy of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for the National Provider Identifier (NPI) number 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:

[https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/PEB\\_Dec2005\\_7183\\_2.pdf](https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/PEB_Dec2005_7183_2.pdf).

## **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 12)
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 box and provide the date of conviction if applicable.
6. Check the appropriate box and provide the date of final judgment if applicable.
7. Check the appropriate box 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 the 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 California Code of Regulations, Title 22, 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 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



**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

**For State Use Only**

- 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.

**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).

National Provider Identifier (NPI) (attach copy of CMS/NPPES confirmation)	Date
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**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 CCR, Title 22, Section 51000.6)
- \*Cumulative change of 50 percent or more in person(s) with ownership or control interest (per CCR, Title 22, Section 51000.15)
- \*Sale of assets (50 percent or more, per CCR, Title 22, Section 51000.30)

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 CCR, Title 22, Section 51000.51.

Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to CCR, Title 22, Section 51000.55)

A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint and Several Liability."

**For items above marked with \* indicate effective date:** \_\_\_\_\_

**Indicate the change of ownership date:** \_\_\_\_\_



**I. Professional and Established Place of Business Information**

**Type of entity**

- Sole Proprietor (unincorporated)   
  Professional Medical Corporation   
  Nonprofit Corporation  
 Partnership (Attach legible copy of agreement)   
 Corporate number: \_\_\_\_\_   
 Type of nonprofit: \_\_\_\_\_  
 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 (Attach a legible copy of the Permit issued by your Medical Licensing Board)

Effective date

4. Business address (number, street, suite)

City

County

State

ZIP code (9-digit)

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)

City

State

ZIP code (9-digit)

6. Current Mailing address (P.O. Box number or address number, street, suite number)

City

State

ZIP code (9-digit)

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

7. Previous business address (number, street, suite)

City

State

ZIP code (9-digit)

8. Medical license number (Attach a legible copy)

List specialty(ies)

Yes    No

Board-certified          
 Board-eligible       

9. Medicare/other NPI (see instructions)

10. Primary taxonomy code

Taxonomy code

Taxonomy code

11. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form)

12. Social Security Number – If sole proprietor not using a TIN, you must disclose this number (see Privacy Statement on page 12)

13. Clinical Laboratory Improvement Amendment (CLIA) certificate number (Attach a legible copy)

14. State Laborator 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)

Insurance policy number

Date policy issued (mm/dd/yyyy)

Expiration date (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

ZIP code (9-digit)

2. Driver's license or state-issued identification number and state of issuance (Attach a 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:

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 the final judgment:

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:

8. Do you, the applicant/provider, currently participate or have you **ever** participated as a provider in the Medi-Cal program or in any other 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
<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare			
<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare			

10. Has the individual license, certificate or other approval to provide health care services 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 services 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)

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).  N/A

**Submit copies of all documents** pertaining to the arrangement(s) including terms and conditions. See CCR, Title 22, Section 51000.50(a)(6).

Fine/Debt	Agency	Date Issued	Date to be Paid in Full

**CONTINUE ON PAGE 11**



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 <input type="checkbox"/> Male <input type="checkbox"/> 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 or contact Denti-Cal at (800) 423-0507.