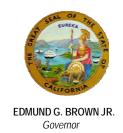


State of California—Health and Human Services Agency Department of Health Care Services



Out-of-State Provider Express Enrollment Form

Dear Out-of-State Provider, in order to enroll as an out-of-state Medi-Cal provider, the following information is required: (Please attach this form to your original claim and mail in.)

Provider/Facility Name:						
		- circle one: Ground	**circle M.D.			
ATTENTION: Service Address: City, State, ZIP:	(If you have a hosp					
"Pay to" Address, if diffe						
ATTENTION: National Provider Identity	(If you have a seco	·			mpany)	
National Provider Identii **License Number:						
**License Issue Date:(DD/MM/YY) **Social Security Number Federal Tax ID Number	er:	(DD/MM/\	YY)			
Business Telephone: (_)					
	er to your claim for JENT, OUT-OF-STA .O. BOX 15507	•	uested bill	ling infor	nation and	send to:

UNIT P.O. BOX 15507 SACRAMENTO, CA 95852-1507 (916) 636-1960

Please disregard this letter if you have already submitted an enrollment form.

**Individual Practitioners Only

For online Medi-Cal provider manuals, access: www.medi-cal.ca.gov