INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL RENDERING PROVIDER/GROUP AFFILIATION/DISAFFILIATION FORM

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 for the purpose of affiliating or disaffiliating rendering providers to billing group enrollments.

Omission of any information on this form, including not signing the form, may result in your records with Medi-Cal not being updated as requested.

Action requested. Enter the date you are completing the form.

A. Affiliate Identification Information

1. "Legal name of rendering provider"—enter the name as listed with the Internal Revenue Service (IRS).
2. "Rendering National Provider Identifier" – enter the rendering affiliate's NPI.
3. "Legal name of group provider" – enter the name of the billing group as reported to the IRS.
4. "Group National Provider Identifier" – enter the billing group's NPI.
5. - 8. Enter the actual enrolled service location(s) at which the rendering provider provides services for the group provider listed in item 3. Include the street name and number, room/suite number or letter, city, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.

B. Rendering Provider Signature

9. Legal name of rendering affiliate. An original signature is required.

   Stamped, faxed, and/or photocopied signatures are ***not*** acceptable. **Rendering provider must also attach a legible copy of their driver's license or state-issued identification card.**

C. Group Provider Signature

10. Legal name of individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the group provider listed, including a delegated official, as defined in the Regulatory Provider Bulletin, *Requirements and Procedures for Medi-Cal Provider Groups Designating Delegated Officials for the Sole Purpose of Signing Affiliation Forms*. An original signature is required. Stamped, faxed, and/or photocopied signatures are ***not*** acceptable.
11. Location of signature and notarization.
12. This form must be notarized by a Notary Public except for those applicants and providers licensed pursuant to Business and Professions Code, Division 2, beginning with Section 500, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

D. Contact Person's Information

13. "Contact person"—enter the name, title/position, contact telephone number, and contact e-mail address of the person who can be contacted regarding this form.

MEDI-CAL RENDERING PROVIDER/GROUP AFFILIATION/DISAFFILIATION FORM

For State Use Only

Important:

- Read all instructions before completing the form.
- 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
- **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.**

Action requested: ☐ New rendering affiliation ☐ Rendering disaffiliation	Date:

A. Affiliate Identification Information

1. Legal name of rendering provider as listed with IRS	2. Rendering national provider identifier (NPI)
3. Legal name of group provider as listed with IRS	4. Group national provider identifier (NPI)

Enter the enrolled service location(s) at which the rendering provider provides services for the group provider listed in item 3. Attach additional pages if needed.

5. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI
6. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI
7. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI
8. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI

B. Rendering Provider Signature

9. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, 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. I understand that it is my responsibility to read the manual and its updates.

Printed legal name of rendering provider (last, first, middle)

Original signature of rendering provider

ATTACH A LEGIBLE COPY OF RENDERING PROVIDER'S DRIVER'S LICENSE OR STATE-ISSUED ID

C. Group Provider Signature

10. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, 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. I understand that it is my responsibility to read the manual and its updates. I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

Printed legal name of person signing this affiliation with authority to legally bind the group listed. Please see instructions under number 10 for who can sign. (last, first, middle)

Original signature of person signing this affiliation with authority to legally bind the group listed

11. Executed at: _____ (City), _____ (State), on _____ (Date)

12. 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.

D. Contact Person's Information
13. 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 this form 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.