State of California
Health and Human Services Agency

Department of Health Care Services

"ELECT TO PARTICIPATE"

INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA) APPLICATION

PURPOSE: To confirm that an Indian Health Services (IHS) facility clinic **elects** to participate under the Indian Health Services Memorandum of Agreement (IHS/MOA) program and **agrees to provide** registered American Indian/Alaskan Native data to DHCS on a quarterly basis as a condition of participation in the Medi-Cal program as an IHS/MOA provider.

GENERAL INSTRUCTIONS: Please complete **one application for each** clinic. **Please refer to detailed instructions on page 2 of this application**.

IHS clinic name		NPI number	
Service location address	City	State	ZIP code

INSTRUCTIONS:
Please check option 1 or option 2:

1) ☐ Clinic has been participating in Medi-Cal as a Primary Care Clinic (PCC), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) under Medi-Cal and now elect to enroll as an IHS/MOA provider.

Please check: ☐ State Licensed Clinic ☐ Not State Licensed

2) ☐ Clinic is **NOT** currently a Medi-Cal provider clinic but **elects** to participate in Medi-Cal as an IHS/MOA provider.

Signature	Date	Telephone number
Print name	Title	

Please return this application to: Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Faxed applications will not be accepted.

INSTRUCTIONS

IHS CLINIC NAME: Enter the clinic name that wishes to enroll as an IHS/MOA provider.

NPI NUMBER: Enter the complete 10-digit National Provider Identifier (NPI) number.

SERVICE LOCATION ADDRESS: Enter the street address, city, and ZIP code of the clinic. Do not enter a P.O. Box address. The address must represent the physical location where services are rendered.

PCC OR FQHC/RHC PROVIDER: Check if the clinic participates as a PCC, FQHC, or RHC under the Medi-Cal program.

LICENSED PROVIDER: Check if clinic has chosen to maintain clinics or affiliate clinic licensure. Provide copy of licensure with form for each site.

NON-LICENSED PROVIDER: Check if clinic has chosen to not seek licensure as allowed by Health and Safety Code 1206 (C).

NOT MEDI-CAL PROVIDER: Check if the clinic is not currently a Medi-Cal provider clinic but wishes to participate in Medi-Cal as a IHS/MOA provider.

SIGNATURE: Enter the signature of the owner or corporate officer of the clinic.

DATE: Enter the date the application was signed.

TELEPHONE NUMBER: Enter a telephone number of the owner or corporate officer.

PRINT NAME: Print the name of the owner or corporate officer signing the application.

TITLE: Enter the title of the owner or corporate officer signing the application.