



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

Dear Durable Medical Equipment Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. This letter addresses information about the enrollment application process for a specific provider type.

**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 (NPES) confirmation for each NPI listed in the application package. If providers are not eligible to receive an NPI, they should instead enter the word “atypical” in any NPI field. These “atypical providers” will receive a unique Medi-Cal provider number once the application is approved.

An application package must be submitted for all Durable Medical Equipment (DME) providers new to the Medi-Cal program as well as all currently enrolled DME Providers subject to continued enrollment under *California Code of Regulations* (CCR), Title 22, Section 51000.55 or required to submit a new application package under CCR, Title 22, Section 51000.30, subsections (a) through (b).

Applicants and providers may be required to submit an application fee or proof of payment to or enrollment with Medicare or other state Medicaid programs. Effective January 1, 2013, the Department of Health Care Services (DHCS) requires certain applicants and providers to submit an application fee when requesting an enrollment action. The application fee collected is used to offset the cost of conducting the required screening as specified in Title 42 Code of Federal Regulations 455 Subpart E. Please reference the Medi-Cal Regulatory Provider Bulletin, “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460,” for further information.

Currently, DME providers are designated as “high” categorical risk level. Federal law requires State Medicaid Agencies (Medi-Cal in California) to establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid program. Federal law mandates that Medi-Cal screen all initial applications, including applications for a new practice location and any applications received in response to a re-enrollment or a revalidation of enrollment request based on a categorical risk level of “limited,” “moderate,” or “high.” An applicant or provider is subject to the “high” risk level of screening if the provider category is designated by the DHCS as “high” risk. If the DME Moratorium is lifted, DME providers

will be subject to screening as a “high” risk level, in accordance with 42 Code of Federal Regulation Sections 424.518, 455.434, and 455.450; and *Welfare and Institutions Code* (W&I Code) Section 14043.38.

Due to the current 180-day moratorium, DHCS is not accepting enrollment applications from DME providers located outside of California and in the California counties of Los Angeles, Orange, Riverside or San Bernardino, except for those eligible for an exemption as indicated below. This moratorium expires on March 5, 2017, and is in accordance with W&I Code, Section 14043.55. As stated in the W&I Code, this moratorium may be continued or repeated when the DHCS Director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

This moratorium does not apply to:

1. DME applicants who for the purpose of the Medi-Cal program choose to be enrolled for medically necessary lactation aids and shall be reimbursed for items mentioned in the Medi-Cal provider manual for Lactation Management Aids (found in *Durable Medical Equipment [DME]: Bill for DME [dura bil dme]*).
  2. DME applicants who for the purpose of the Medi-Cal program choose to be enrolled as Customized Wheelchair DME (CWDME) providers and/or Oxygen and Respiratory Equipment DME (OREDME) providers.
    - a) CWDME providers shall sell, service and/or repair customized wheelchairs as medically necessary for Medi-Cal beneficiaries. An enrolled CWDME provider shall be reimbursed for items authorized in the Medi-Cal provider manual for wheelchairs, modifications and accessories.
    - b) OREDME providers shall sell, service and/or repair Oxygen and Respiratory Equipment. An enrolled provider shall be reimbursed for items authorized in the Medi-Cal provider manual, under the Oxygen and Respiratory Equipment Group and deemed medically necessary for Medi-Cal beneficiaries.
  3. Current Medi-Cal enrolled DME providers seeking to add a new business location in the same county, so long as the DME provider enrolled in the program after October 12, 1999, and is not adding new business activities, categories of service, or billing codes, other than those approved for enrollment at its existing location;
  4. Applicants who will be enrolled solely for reimbursement of Medicare cost sharing amounts;
  5. An application that is submitted because an existing Medi-Cal enrolled DME provider, which is part of a group of affiliated corporations (as defined by California Corporations Code, Section 150), is transferring its assets to an affiliated corporation that is a part of the same group of affiliated corporations;
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6. An application that is submitted because an existing Medi-Cal enrolled DME provider, who is an individual operating as an unincorporated sole proprietorship, has incorporated that sole proprietorship, with all of the existing issued shares of the new corporation being owned by that individual who is also the president of the new corporation;
7. An application that is submitted because there has been a cumulative change of 50 percent or more in the person(s) with an ownership or control interest in an existing Medi-Cal enrolled DME provider, provided that the change only consists of a reorganization or consolidation among existing person(s) previously identified in the last complete application package that was approved for enrollment as having an ownership interest in the provider totaling 5 percent or greater;
8. Applications submitted pursuant to CCR, Title 22, Section 51000.55 or Section 51006, Subparts (a)(1), (a)(2), (a)(3) or (a)(5);
9. Applications submitted pursuant to CCR, Title 22, Section 51000.30(b)(3) provided that there is no change in the person(s) previously identified in the last complete application package that was approved for enrollment as having a control or ownership interest in the provider totaling 5 percent or greater;
10. Applications submitted pursuant to CCR, Title 22, Section 51000.30(a) only because an existing Medi-Cal enrolled DME provider has changed its location provided that its previous business was located in one of the following counties: Los Angeles, Orange, Riverside, or San Bernardino and is not adding new business activities, categories of service or billing codes other than those approved for enrollment;
11. Applicants that are the only person or entity in the United States that provides a specific product or service that is a Medi-Cal covered benefit; or,
12. Any applicant offering services or replacement parts, not available from an enrolled Medi-Cal provider on the date of application, for a Medi-Cal covered medical device.

If you are eligible according to the criteria outlined above, please complete a new application package consisting of a *Medi-Cal Durable Medical Equipment Provider Application* (DHCS 6201, rev. 05/14), a *Medi-Cal Disclosure Statement* (DHCS 6207, rev. 02/15), a *Medi-Cal Provider Agreement* (DHCS 6208, rev. 11/11), and any required attachments.

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Return the completed application package to:

Department of Health Care Services  
Provider Enrollment Division  
MS 4704  
P.O. Box 997412  
Sacramento, CA 95899-7412

Please include with your application package a cover letter explaining in detail the circumstances that qualify your business as an exception to the current moratorium. If you cannot enroll at this time, please contact our office in September 2016 to ascertain the status of the moratorium.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned.

It is your responsibility to report to DHCS any modifications to information previously submitted within 35 days from the date of the change. Most changes can be reported on a *Medi-Cal Supplemental Changes* form (DHCS 6209, rev. 12/14). However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, a change of business address, or one of the other changes identified in 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 DME 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](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, form completion 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 to [PEDCorr@dhcs.ca.gov](mailto:PEDCorr@dhcs.ca.gov).

In order to submit claims electronically, providers must request a submitter number by completing a *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](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 to [PEDCorr@dhcs.ca.gov](mailto:PEDCorr@dhcs.ca.gov).

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A submitter billing number for an existing DME provider is not transferable. A new *Medi-Cal Telecommunications Provider and Biller Application/Agreement* must be submitted each time a new enrolled location is approved.

If you have any questions about completing the *Medi-Cal Telecommunications Provider and Biller Application/Agreement*, call the TSC at 1-800-541-5555 and select the option for Computer Media Claims (option 4, followed by option 2).

Provider Enrollment Division

Enclosures

(Rev. 09/16)



## INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL DURABLE MEDICAL EQUIPMENT PROVIDER APPLICATION

**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.

This form is part of an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a MEDI-CAL DISCLOSURE STATEMENT (DHCS 6207) and a MEDI-CAL PROVIDER AGREEMENT (DHCS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) by clicking the “Provider Enrollment” link.

**Omission of any information or documentation on this form or failure to sign any of these documents may result in any of the denial actions identified 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.**

**You must submit an application fee and/or fee waiver request unless you are exempt from paying the fee. DHCS will only accept a cashier’s check made payable to the State of California, Department of Health Care Services, in the amount required for the calendar year in which DHCS receives your application. Information regarding the current fee is available on the DHCS Web site at [www.dhcs.ca.gov](http://www.dhcs.ca.gov). Failure to submit a cashier’s check when required may result in denial of your application.**

Enrollment action requested – check all that apply. Enter the date you are completing the application.

“New provider” – check if the applicant is not currently enrolled in the Medi-Cal program as a provider with an active provider number. Include the NPI for the business address indicated in item 4.

“Change of business address” – check if the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

“Additional business address” – check if the applicant is currently enrolled in the Medi-Cal program and is requesting enrollment for an additional business location.

“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 CCR, Title 22, 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 CCR, Title 22, 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.

“Sales 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.

“Continued Enrollment” – check if the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to CCR, Title 22, Section 51000.55. List current provider number(s) in the space provided on page 5.

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 CCR, Title 22, Section 51000.51.

**Medi-Cal Application Fee – check all that apply.**

Check the box labeled “I am currently enrolled in the Medicare program...” if you are currently enrolled in the Medicare program at the business address indicated on page 5, item 4 of the application, and under the legal name listed on page 5, item 1 of the application. Provider locations are exempt from paying the fee if currently enrolled in Medicare pursuant to W&I Code Section 14043.25(d) and the provider bulletin, “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460,” January 2013. Verification is required: provide an official notice from the enrolling agency that specifies the applicant’s/provider’s legal name and physical business address as identified on this application.

Check the box labeled “I am currently enrolled in another State’s...” if you are currently enrolled in another State’s Medicaid or Children’s Health Insurance Program (CHIP) at the business address indicated on page 5, item 4 of the application, and under the legal name listed on page 5, item 1 of the application. Provider locations are exempt from paying the fee if currently enrolled in another State’s Medicaid or CHIP pursuant to W&I Code Section 14043.25(d) and the provider bulletin, “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460, January 2013. Verification is required: provide an official notice from the enrolling agency that specifies the applicant’s/provider’s legal name and physical business address as identified on this application.

Check the box labeled “I have paid the application fee...” if you have paid the application fee to a Medicare contractor or another State’s Medicaid or CHIP for the enrollment of the business address indicated on page 5, item 4 of the application, and under the legal name listed on page 5, item 1 of the application. Providers are exempt from paying the fee if they have already paid the fee to a Medicare contractor or another State’s Medicaid or CHIP for the same business address pursuant to W&I Code Section 14043.25(d) and the provider bulletin, “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460,” January 2013. Verification is required: provide official proof of payment that specifies the applicant’s/provider’s legal name and physical business address as identified on this application.

Check the box labeled “I have included an application fee...” if you included with the application either an application fee cashier’s check, fee waiver request, or both. Providers that do not meet the exemptions specified in the above boxes are required to pay the fee pursuant to W&I Code Section 14043.25(d) and the provider bulletin “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460,” January 2013. **DHCS can only accept a cashier’s check as payment of the application fee – made payable to the State of California, Department of Health Care Services.**

“Type of entity” – check the box which applies to 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” is the name listed with the Internal Revenue Service (IRS).
2. “Business name” is the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application.
3. “Business telephone number” is 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” is 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 or commercial box is not acceptable.
5. “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. “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” is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.
8. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
9. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
10. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 7.)

11. Enter any local business license numbers or permits for any city or county, or city and county where you conduct your business activities and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
12. Enter any 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.
13. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
14. Check the appropriate boxes and complete all requested information in this section.
15. Check the appropriate boxes and complete all requested information in this section.
16. Check the appropriate boxes regarding your ownership and/or leasehold interest in the building in which your business is located. If you lease the building, attach a copy of the written lease agreement. If anyone other than you holds an ownership interest in the building, enter the name(s), phone number(s), and address(es) of that person(s).
17. Check the appropriate box regarding whether you have the administrative and fiscal foundation to enable your business to survive as a going concern.
18. Check the appropriate boxes and complete all requested information in this section.
19. Check the appropriate box to indicate whether you have the necessary equipment, supplies and facilities to carry out your business and to comply with CCR, Title 22, Section 51476.
20. Check the appropriate box and complete all requested information in this section.
21. Check the appropriate box and complete all requested information in this section.
22. Check the appropriate box and complete all requested information in this section.
23. Check the appropriate box indicating whether the applicant or provider provides "custom rehabilitation equipment" and "custom rehabilitation technology services" to Medi-Cal beneficiaries. If you answer yes, check the appropriate box whether the applicant or provider has on staff, either as an employee or independent contractor, or the applicant or provider has a contractual relationship with, a "qualified rehabilitation professional" who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment.

"Custom rehabilitation equipment" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.

"Custom rehabilitation technology services" means the application of enabling technology systems designed and assembled to meet the needs of a specific person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate, the documentation of medical necessity, the selection, fit, customization, maintenance, assembly, repair replacement, pick-up and delivery, and testing of equipment and parts, and the training of an assistant caregiver and of a patient who will use the equipment or individuals who will assist the client in using the equipment.

"Qualified rehabilitation professional" means an individual to whom any one of the following applies:

- (a) The individual is a physical therapist licensed pursuant to the Business and Professions Code, occupational therapist licensed pursuant to the Business and Professions Code, or other qualified health care professional approved by the Department.
- (b) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers, or other credentialing organization recognized by the Department.
- (c) The individual has successfully passed one of the following credentialing examinations administered by the Rehabilitation Engineering and Assistive Technology Society of North America:
  - (i) The Assistive Technology Supplier examination.
  - (ii) The Assistive Technology Practitioner examination.
  - (iii) The Rehabilitation Engineering Technologist examination.

24. Check the applicable lines corresponding to all business activities of the applicant or provider and give the percentage of each of those activities. Attach copies of all applicable licenses and/or certifications. Total the percentages. The percentages must total 100 percent. Calculate percentages based upon total dollar sales, including Medi-Cal, Medicare, all other third party payors, and cash transactions for the year immediately preceding filing of this application. If a change of 20 percent or more in total business activity is anticipated within the next year, compared to business activity in the year immediately preceding the filing of this Application, adjust the percentage listings to reflect this anticipated change.
  25. Proof of 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 of the insurance agent, fax number of the insurance agent and e-mail address of the insurance agent. You must attach a copy of your certificate of insurance for the identified business address to the application.
  26. Check the appropriate box to indicate whether you have Workers' Compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.
  27. "Printed name of provider." Enter the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Care Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
  28. Check the gender of the individual named in number 27.
  29. Enter the driver's license or state-issued identification number and state of issuance of the individual listed in number 27. 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.
  30. Enter the date of birth of the individual named in number 27.
  31. Enter the social security number of the individual named in number 27. (Optional—see Privacy Statement on page 7).
  32. An original signature of the individual named in number 27 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this application.**
  33. 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 it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.
  34. 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 information may result in the application package being returned deficient for item(s) that an applicant can readily provide by fax or telephone.
- ✓ Remember to attach a legible copy of the following, if applicable:
- Verification of enrollment in Medicare or another State's Medicaid/CHIP (if applicable)
  - Proof of application fee payment to a Medicare contractor or another State's Medicaid/CHIP (if applicable)
  - Fictitious Business Name Statement
  - TIN verification
  - Seller's Permit
  - Any local business license numbers/permits
  - Home Medical Device Retailer license
  - Home Medical Device Retailer Exempted license
  - Signed Medi-Cal Disclosure Statement (DHCS 6207)
  - Signed Medi-Cal Provider Agreement (DHCS 6208)
  - Driver's license or state-issued identification card of individual signing the application
  - Successor Liability Agreement (if applicable)
  - Certificate of Liability Insurance
  - Proof of Workers' Compensation Insurance
  - National Provider Identifier (NPI) verification (CMS/NPPES confirmation)
  - Lease Agreement



# MEDI-CAL DURABLE MEDICAL EQUIPMENT PROVIDER APPLICATION

**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.**

Provider number (NPI): _____ Enrollment action requested ( <b>check all that apply</b> ) <input type="checkbox"/> New provider <input type="checkbox"/> Change of business address <input type="checkbox"/> Additional business address <input type="checkbox"/> New Taxpayer ID number <input type="checkbox"/> Change of ownership (per CCR, Title 22, Section 51000.6) <input type="checkbox"/> *Acceptance of "Successor Liability with Joint and Several Liability" (per CCR, Title 22, Sections 51000.24.1, 51000.32) <input type="checkbox"/> *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per CCR, Title 22, Section 51000.15) <input type="checkbox"/> *Sale of assets (50 percent or more, per CCR, Title 22, Section 51000.30) For items marked with * indicate the effective date: ___/___/____.	Date _____  <input type="checkbox"/> 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) <input type="checkbox"/> I intend to use my current 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. * <b>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 CCR, Title 22, Section 51000.32 entitled "Requirements for Successor Liability with Joint &amp; Several Liability."</b> Indicate the change of ownership effective date: ___/___/____.
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**Medi-Cal Application Fee (check all that apply)**

I am currently enrolled in the Medicare program at this business address and under this legal name. (Attach verification)

I am currently enrolled in another State's Medicaid or Children's Health Insurance Program (CHIP) at this business address and under this legal name. (Attach verification)

I have paid the application fee to a Medicare contractor or another State's Medicaid or CHIP at this business address and under this legal name. (Attach proof of payment)

I have included an application fee check and/or an application fee waiver request with this application. (Attach cashier's check and/or waiver request)

**Type of entity (check one)**

<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> Partnership (attach legible copy of agreement)	<input type="checkbox"/> Government entity
<input type="checkbox"/> Corporation: Corporate number: _____ State incorporated: _____	<input type="checkbox"/> Limited Liability Company (LLC): LLC number: _____ State registered/FILED: _____	<input type="checkbox"/> Nonprofit Corporation Type of nonprofit: _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list the Fictitious Business Name Statement number _____	Effective date _____		
(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)				
4. Business address (number, street) _____	City _____	County _____	State _____	Nine-digit ZIP code _____
5. Pay-to address (number, street, P.O. Box number) _____	City _____	State _____	Nine-digit ZIP code _____	
6. Mailing address (number, street, P.O. Box number) _____	City _____	State _____	Nine-digit ZIP code _____	
<b>For a change of business address, enter location moving from:</b>				
7. Previous business address (number, street) _____	City _____	State _____	Nine-digit ZIP code _____	

8. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code
9. Taxpayer Identification Number (TIN) (attach a legible copy of the IRS form)	10. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 7.)	
11. Any local business license numbers/permits (attach legible copies)	12. Medicare/Other NPI (see instructions)	13. Seller's Permit number (attach a legible copy)

14. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies, and/or medical supply items? .....  Yes  No  
 If no, please explain: \_\_\_\_\_

Do you have adequate inventory and staff to meet both your current and your anticipated sales and service requirements?.....  Yes  No  
 If no, please explain: \_\_\_\_\_

15. Does your business have regular and permanently posted business hours?.....  Yes  No  
 Business days and hours of operation: Days: \_\_\_\_\_ Hours: \_\_\_\_\_  
 Does your business have permanently attached signage that identifies the name of the business as stated on this application?  Yes  No

16. Do you own the building in which your business is located? .....  Yes  No  
 Do you lease the building in which your business is located? .....  Yes  No  
 (If you answered yes, attach a copy of the written lease agreement to the application.)  
 If anyone other than you holds an ownership interest in the building, provide the following information about that person(s):  
 (Use additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

17. Do you have the administrative and fiscal foundation to enable your business to survive as a going concern? .....  Yes  No

18. Are your equipment and/or supplies:  
 A. In stock on the premises, or  
 B. In a warehouse under the applicant's or provider's direct control.  
 If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	Nine-digit ZIP code
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Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

19. Do you have the necessary equipment, office supplies, and facilities available to carry out your business, including storing and retrieving such records as are necessary to fully disclose the type and extent of services provided to Medi-Cal beneficiaries? (See CCR, Title 22, Section 51476.) .....  Yes  No

20. Does your business involve the trade, sale, rental, or transfer of upholstered-furniture (including wheelchairs) or bedding? .....  Yes  No  
 If yes, provide your Home Medical Device Retailer license number \_\_\_\_\_, or your retail furniture and bedding dealer's license or retail furniture dealer's license number \_\_\_\_\_.

21. Does your business involve the trade, sale, rental, or transfer of medical devices or durable medical equipment/devices for use in the home to treat acute or chronic illness or injuries? .....  Yes  No  
 If yes, provide your Home Medical Device Retailer license number \_\_\_\_\_.

22. Does your business involve the trade, sale, rental, or transfer of dangerous or legend drugs and/or dangerous or legend medical equipment/devices? .....  Yes  No  
 If yes, provide your Home Medical Device Retailer Exemptee license number \_\_\_\_\_.

23. Does the applicant provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? .....  Yes  No  
 If yes, does the applicant have on staff, either as an employee or independent contractor, or does the applicant have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment? .....  Yes  No

24. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give a percentage for each of the following business activities for this applicant. Total the percentages at the end of this question; do not leave anything blank, place zero (0) if it does not apply to you. Percentages must total 100 percent. (See instructions for computing percentages.)

- A. \_\_\_\_\_ % Ambulation Devices (describe): \_\_\_\_\_
  - B. \_\_\_\_\_ % Basic Rehabilitation Equipment (describe): \_\_\_\_\_
  - C. \_\_\_\_\_ % Specialized Rehabilitation Equipment (describe): \_\_\_\_\_
  - D. \_\_\_\_\_ % Basic Wheelchairs, Modifications & Accessories (describe): \_\_\_\_\_
  - E. \_\_\_\_\_ % Specialized Wheelchair, Modifications & Accessories (describe): \_\_\_\_\_
  - F. \_\_\_\_\_ % Bathroom Equipment
  - G. \_\_\_\_\_ % Communication Devices & Speech Generating Devices
  - H. \_\_\_\_\_ % Diabetic Supplies & Equipment
  - I. \_\_\_\_\_ % Dialysis Supplies & Equipment
  - J. \_\_\_\_\_ % Hospital Beds & Accessories; Decubitus Care Equipment; Wound Care; Patient Lifts; Traction
  - K. \_\_\_\_\_ % Infusion Equipment & Supplies (describe): \_\_\_\_\_
  - L. \_\_\_\_\_ % Incontinence Medical Supplies (describe): \_\_\_\_\_
- You must comply with Article 3.7 of the Welfare and Institutions Code.**
- M. \_\_\_\_\_ % Lactation Supplies & Equipment
  - N. \_\_\_\_\_ % Non-Surgical Electronic Devices; Pneumatic Compressors & Supplies
  - O. \_\_\_\_\_ % Respiratory Equipment & Supplies
  - P. \_\_\_\_\_ % Surgical Related Devices
- \_\_\_\_\_ % **TOTAL**

**25. Proof of Liability Insurance—Applicant must attach a copy of their certificate of insurance for the business address.**

Name of insurance company \_\_\_\_\_

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

26. Does the applicant have Workers' Compensation insurance as required by state law?  Yes  No  N/A  
 If applicable, attach proof of maintenance of Workers' Compensation insurance. If not applicable, check N/A and provide an explanation:

**Information About Individual Signing This Application**

27. Printed name of provider (last) (first) (middle) 28 Gender  
 Male  Female

29. Driver's license or state-issued identification number and state of issuance (attach a legible copy) 30. Date of birth 31. Social security number (Optional—see Privacy Statement below.)

**32. I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).**

Signature of provider \_\_\_\_\_ Title \_\_\_\_\_

Executed at: \_\_\_\_\_, \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (City) (State) (Date)

33. **Notary Public** — Please see instructions under number 33 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

**34. Contact Person's Information**

Check here if you are the same person identified in item 27. 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 ( )
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**Privacy Statement  
 (Civil Code Section 1798 et seq.)**

All information requested on the application, the disclosure statement, and the provider agreement 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). 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. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in 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.