JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency

Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. 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, California, 95899-7412

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

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 (NPPES) 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 fields. These "atypical providers" will receive a unique Medi-Cal provider number once the application is approved.

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, 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 Regulation 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.

It is your responsibility to report to the DHCS any modifications to 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 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 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. 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. 02/08).

Enrollment forms are available at www.medi-cal.ca.gov or by contacting the Telephone Service Center at (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* 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 on the previous page or via email at 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. 11/13), available on the Medi-Cal Website at www.medi-cal.ca.gov, under "Provider Resources", "Forms", then "Billing."

Provider Enrollment Division

Enclosures (Rev. 2/17)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PROVIDER GROUP 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) 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. 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. Indicate the business address applicant is moving from.

"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) has been 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 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.

"Sale or transfer 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.

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 8, item 4 of the application, and under the legal name listed on page 8, 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 8, item 4 of the application, and under the legal name listed on page 8, 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 8, item 4 of the application, and under the legal name listed on page 8, 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. Physician provider groups are to submit a legible copy of the Fictitious Business Name Permit issued by the Medical Board of California.
3. “Provider group 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 phone, 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.
   a. Check whether the business address is a licensed health facility as defined in Sections 1250, 1250.2 and 1250.3 of the Health and Safety Code. Check whether services will be rendered at only the business address indicated. If not, you must submit a separate application for each business address unless you qualify for an exception pursuant to W&I Code Section 14043.15(b)(2). See the ‘Facility-Based Provider’ bulletin on the Medi-Cal Web site (www.medi-cal.ca.gov) for the requirements to qualify for that exception.
5. “Pay-to address” is the address to which payment will be mailed. 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 address 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 the Taxpayer Identification Number (TIN) issued by the IRS under the name of the provider group or provider group applicant; or enter social security number (see Privacy Statement on page 6). Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
9. Enter any additional NPI for the business address indicated in item 4, registered with other carriers including, but not limited to Medicare. Attach CMS/NPPES verification for each. Providers not eligible to receive an NPI (atypical providers) should submit a Medicare billing number.

10. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.

11. Enter each taxonomy code(s) associated with your NPI. Attach additional sheets if necessary.

12. Indicate the type of provider group (e.g. Audiologists, Certified Nurse Midwives, Chiropractors, Occupational Therapists, Optometrists, Orthotists, Orthotists and Prosthetists, Nurse Anesthetists, Nurse Practitioners, Physicians, Physical Therapists, Podiatrists, Prosthetists, Psychologists, Respiratory Therapists, Speech Therapists).

13. If this is a physician provider group, list the specialty(ies).

14. List the name, professional license number, social security number, and date of birth of all rendering providers in the provider group. Attach additional sheets, if necessary. Except as noted below, rendering providers not already currently enrolled as Medi-Cal providers who are enrolling to render services in the provider group must use the "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers" (DHCS 6216). Provision of the social security number is optional (see Privacy Statement on page 6). The following providers, enrolling to render services in a Medi-Cal enrolled provider group, must use the " Medi-Cal Nonphysician Medical Practitioner and Licensed Midwife Application" (DHCS 6248), the "Medi-Cal Provider Agreement" (DHCS 6208) and the "Medi-Cal Disclosure Statement" (DHCS 6207) to enroll:

    Licensed Midwives
    Nurse Anesthetists
    Nurse Midwives
    Nurse Practitioners
    Physician Assistants

15a. If this is a physician provider group, enter information on whether the physicians have hospital privileges. If not please explain why (if arrangements have been made with another physician for admitting patients, please provide his/her name, address, and telephone number). Provide the name(s) of the physician(s) and the name(s), address(es) and telephone number(s) of the hospital(s) where current privileges have been granted. Attach an additional sheet supplying all of the requested information for each hospital if needed.

15b. If this is a physician provider group, enter information on whether any of the physicians have had privileges at any hospitals that were suspended or revoked. If so, provide the name(s) of the physician(s) and the name(s), address(es), and telephone number(s) of the hospital(s). Attach an additional sheet supplying all of the requested information for each hospital, if needed.

15c. If this is a physician provider group, enter information on whether the applicant or provider has voluntarily resigned or otherwise surrendered their hospital privileges. If so, provide the name(s) of the physician(s) and the name(s), address(es), and telephone number(s) of the hospital(s). Attach an additional sheet supplying all of the requested information for each hospital if needed.

16. Enter the Clinical Laboratory Improvement Amendment (CLIA) Certificate number. Attach a legible copy of the CLIA Certificate.

17. Enter the State Laboratory License/Registration number. If this does not apply to you, enter "N/A." Attach a legible copy of the license/registration.

18. Enter any local business license or permit numbers for any city and/or county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
19. Enter the requested information. Attach to this application a legible copy(ies) of applicant's current Certificate of Insurance for Liability Insurance that covers premises and operation for this address. If all services are provided exclusively in a licensed hospital or licensed health facility (as defined in Health and Safety Code, Section 1250), please provide a cover letter with the facility information as proof of liability insurance coverage in accordance with the February 2005 provider bulletin regarding Facility-Based Providers.
20. Enter the requested information. Attach a legible copy(ies) of applicant's current Certificate of Insurance for Professional Liability Insurance (malpractice insurance) to this application.
21. 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.
22. "Printed name of provider"—print 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.
23. Check the gender of the individual named in number 22.
24. Enter the driver's license or state-issued identification card number and state of issuance of the individual named in number 22. 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.
25. Enter the date of birth of the individual named in number 22.
26. Enter the social security number of the individual named in number 22. Provision of the social security number is optional (see Privacy Statement on page 11).
27. An original signature of the individual named in number 22 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.**
28. 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 Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.
29. Enter contact information for the provider or other authorized person designated for Provider Enrollment staff to contact for clarification. 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
- ☐ Proof of application fee payment to a Medicare contractor or another State's Medicaid/CHIP
- ☐ TIN verification
- ☐ Seller's Permit
- ☐ Fictitious Business Name Statement or Fictitious Name Permit
- ☐ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ☐ Signed Medi-Cal Provider Agreement (DHCS 6208)
- ☐ Complete "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement For Physician/Allied/Dental Providers" (DHCS 6216) for each rendering provider being added to the provider group if the rendering provider is not currently enrolled as a Medi-Cal Provider"
- ☐ Applicable certifications
- ☐ Driver's license or state-issued identification card of individual signing the application
- ☐ CLIA Certificate
- ☐ State Laboratory License/Registration
- ☐ Certificate of Liability Insurance
- ☐ Certificate of Professional Liability Insurance
- ☐ Proof of Workers' Compensation Insurance
- ☐ Medicare enrollment verification
- ☐ Successor Liability Agreement
- ☐ National Provider Identifier (NPI) verification (CMS/NPPES verification)

MEDI-CAL PROVIDER GROUP APPLICATION

For State Use Only

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
- **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): ____________________

Date:

Enrollment action requested **(check all that apply)**

☐ New provider
☐ Change of business address
☐ Additional business address
☐ New taxpayer ID
☐ *Change of ownership (per CCR, Title 22, Section 51000.6)
☐ *Acceptance of “Successor Liability with Joint and Several Liability” (per CCR, Title 22, Sections 51000.24.1, 51000.32)
☐ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per CCR, Title 22, Section 51000.15)
☐ *Sale or transfer of assets (50 percent or more) (per CCR, Title 22, Section 51000.30)

For items above marked with * indicate effective date: _____

☐ 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.)
☐ 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.
***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 & Several Liability.” Indicate the change of ownership effective date: _____

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 under this legal name. (Attach verification)
☐ I have paid the application fee to a Medicare contractor or another State’s Medicaid or CHIP for this business address 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.

Type of entity (check one)

☐ Sole proprietor	☐ Corporation:	☐ Limited Liability Company:	☐ Nonprofit:
☐ Partnership	Corporate number: ________	LLC number: _____________	Type: _______
☐ Government entity	State incorporated: ________	State registered/filed: ______	☐ Other: _______

1. Legal provider group name (as listed with the IRS)

2. Business name, if different

Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the Fictitious Business Name Statement/Permit number and effective date (Attach copy)	3. Provider group telephone number

4. Provider group business address (number, street, suite and/or room)	City	County	State	ZIP code (9-digit)

a. If you are applying as a **facility-based provider**, complete this section:
This address is a licensed hospital/health facility. ☐ Yes ☐ No
If yes, check the option that applies:
☐ All services are provided at this one facility location **OR**
☐ Services are provided at more than one licensed health facility.
(Attach a list of all business addresses where services are provided.)

5. Pay-to address (number, street, P.O. box number)	City	State	ZIP code (9-digit)
6. Mailing address (number, street, P.O. box number)	City	State	ZIP code (9-digit)

For a change of business address, enter location moving from:

7. Previous business address (number, street)	City	State	ZIP code (9-digit)

8. Taxpayer identification number (TIN) (Attach legible copy of the IRS form) or social security number	9. Medicare/Other NPI (see instructions)	10. Seller's Permit number (Attach a legible copy)

11. Primary Taxonomy code	Taxonomy code	Taxonomy code

12. Type of provider group	13. If physician(s), list specialty(ies)

14. List all providers rendering in the provider group. (Use additional sheets if necessary. Attach complete application package for each provider not enrolled in the Medi-Cal program.)

Name	Provider Number	License Number	Social Security Number	Date of Birth

15. **Hospital Privileges** (answer if a physician provider group)

a. Do all of your physicians have current hospital privileges? ☐ Yes ☐ No

If no, please explain: ______

If yes, please enter the following (attach additional sheets if needed):

Name of physician	Name of Hospital		Telephone number
Address (number, street)	City	State	ZIP code (9-digit)
Name of physician	Name of Hospital		Telephone number
Address (number, street)	City	State	ZIP code (9-digit)

b. Have any of your physician's hospital privileges ever been suspended or revoked? ☐ Yes ☐ No

If yes, please enter the following (attach additional sheets if needed):

Name of physician	Name of Hospital		Telephone number
Address (number, street)	City	State	ZIP code (9-digit)

c. Have any of your physicians ever voluntarily resigned or otherwise surrendered his/her hospital privileges? ☐ Yes ☐ No

If yes, please enter the following (attach additional sheets if needed):

Name of physician	Name of Hospital		Telephone number
Address (number, street)	City	State	ZIP code (9-digit)

16. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy)	17. State Laboratory License/ Registration number (attach a legible copy)	18. Any local business license/permit numbers (attach a legible copy)

19. **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 (mm/dd/yyyy)

Insurance agent's name – (first)	(middle)	(last)	(Jr., Sr. etc)

Telephone number	Fax number	E-mail address

20. **Proof of Professional Liability Insurance – Applicant must attach a copy of their certificate of (malpractice) insurance.**

Name of insurance company

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

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

____

Information About Individual Signing This Application

22. Printed name of provider (last, first, middle)	23. Gender ☐ Male ☐ Female

24. Driver's license or state-issued ID number and state of issuance (attach a legible copy)	25. Date of birth	26. Social security number (***Optional*** – see Privacy Statement below)

27. **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: ______________________ (City), ______________ (State) on ______________ (Date)

28. Notary Public – Please see instructions under number 28 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

29. **Contact Person's Information**
☐ Check here if you are the same person identified in item 22. 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

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.