Provider: Medi-Cal Hardcopy Biller Notification Form

Page updated: August 2020

Provider Name: ______________________________

DBA (if applicable): ______________________________

Provider Number: ______________________________

Provider Address: ______________________________

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Previous submitter name (if applicable): ______________________________

Billing Service: ______________________________

Billing Service Address: ______________________________

____

Effective Date: ______________

Provider Signature: ____________________ Date: ____________________

This form is to be completed and returned to:

Department of Health Care Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413