Biller: Medi-Cal Hardcopy Biller Application Agreement

Type of Request

______ Initial submitter number

______ Addition/Deletion of Provider to Submitter No. ______________________________

Billing Service:____

Billing Service Address: ____

____

Previously assigned submitter number (if applicable): ______________________________

List Medi-Cal providers contracted with service agency:

Provider Name	Provider Number	Effective Date

Authorized Applicant's Original 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