



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



**SANDRA SHEWRY**  
Director

**ARNOLD SCHWARZENEGGER**  
Governor

Dear Pharmacy 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:** Effective May 23, 2007, applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Current Medi-Cal providers will be required to submit both the NPI and any Medi-Cal provider numbers issued previously on any application forms submitted to the Department of Health Care Services (DHCS). Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPES) confirmation letter 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.

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

Due to the current 180-day moratorium, DHCS is not accepting enrollment applications from non-chain, non-pharmacist owned pharmacies located in Los Angeles County, except for those eligible for an exemption. This moratorium ends on November 8, 2007, and is in accordance with the *California Welfare and Institutions Code (W & I Code)*, Section 14043.55. As stated in the W & I Code, this moratorium may be extended or repeated when the DHCS Director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

If your business is a non-chain, non-pharmacist owned pharmacy located in Los Angeles County, and is eligible for an exemption according to the criteria outlined in the moratorium (located on the Medi-Cal Provider Enrollment Web site), please complete a new application package consisting of a *Medi-Cal Pharmacy Provider Application* (DHS 6205, rev. 3/07 – DHCS 6205, rev. 7/07), a *Medi-Cal Disclosure Statement* (DHS 6207, rev. 3/07 – DHCS 6207, rev. 7/07), a *Medi-Cal Provider Agreement*

(DHS 6208, rev. 3/07 – DHCS 6208, rev. 7/07), and a cover letter specifically stating the moratorium exemption that you qualify under, including information relating how you qualify for the exemption.

Return the completed application package to:

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

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 the 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 (DHS 6209, rev. 3/07 – DHCS 6209, rev. 7/07). However, you must complete a new application package if you are reporting a change of business ownership of 50 percent or more, a change of business address, or one of the other changes identified in Title 22, CCR 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 Pharmacy, including the option to submit a *Successor Liability with Joint and Several Liability Agreement*.

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 Web site 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 e-mail at [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. 7/07), available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) under “Provider Resources.” Click the “Forms” link and select “Billing.” A submitter number for an existing pharmacy is not transferable.

A new submitter number must be obtained each time a new Medi-Cal Pharmacy provider number is issued by DHCS. 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.

Provider Enrollment Division

Enclosures

(Revised 7/07)

## INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PHARMACY 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 the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.**

**You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation letters for each National Provider Identifier (NPI) submitted with your application package.**

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 with the Medi-Cal program as a provider with an active provider number.

“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) has been issued by the IRS.

“Change of ownership”—check if there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

“Acceptance of Successor Liability with Joint and Several Liability”—check this box only if you are submitting this application pursuant to Title 22, CCR, Section 51000.32 and have already submitted or have enclosed a letter that meets the requirements of Section 51000.32(a)(1).

“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 Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

“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.

“New pharmacy permit”—check if a new pharmacy permit is required from the State Board of Pharmacy pursuant to Business and Professions Code (commencing with Section 4000).

“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 Title 22, CCR, Section 51000.55. List active provider number(s).

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 Title 22, CCR, Section 51000.51.

“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 box 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. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
8. 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).
9. If the business is a sole proprietorship not using a TIN, enter the social security number of the sole proprietor. (See Privacy Statement on page 7).
10. Enter the California State Board of Pharmacy Permit number and expiration date. Attach a legible copy of the current 8½ X 11 permit.
11. Enter other NPI registered with other carriers including, but not limited to Medicare. Attach CMS/NPPES confirmation letter for each. Providers not eligible to receive an NPI (atypical providers) should submit a Medicare billing number.
12. Enter the applicant's or provider's Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the seller's permit.
13. Enter any local business license/permit numbers. Attach a legible copy(ies) to the application.
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 has an ownership interest in the building, enter the name(s), phone number(s), and address(es) of that person(s).
17. Check the applicable box regarding whether you have the administrative and fiscal foundation to enable your business to survive as a going concern.
18. Check the appropriate box to indicate whether you have the necessary equipment, supplies and facilities to carry out your business and to comply with Title 22, CCR, Section 51476.
19. If applicant or provider intends to bill the Medi-Cal program for durable medical equipment, complete this question by providing the following information:
  - Whether the applicant or provider does or does not have a retail business open to the public that meets all local laws and ordinances regarding business licensing and operations.
  - If this is not a retail business open to the public, explain why.
  - Whether the applicant engages in the sale, rental, and/or lease of items either in stock on the premises or in a warehouse under the applicant's direct control.
  - If the sales are of items housed in a warehouse under the applicant's or provider's direct control, enter the address of the warehouse.
  - The name(s), address(es), and telephone number(s) of any individual who holds an ownership interest in the warehouse. Use additional sheets if necessary.
20. Check the applicable box(es) corresponding to all business activities of the applicant or provider and give the percentage of each of those activities. 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. Enter the applicable registration, certificate, and license numbers and attach legible copies. NOTE: Pursuant to Title 22, CCR, Section 51315(e), pharmacists may furnish and bill for only those appliances listed in the Provider Manual and designated by double asterisks (\*\*).
21. 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.
22. 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 email address of the insurance agent. You must attach a copy of your certificate of insurance for the identified business address to the application.
  23. Proof of Professional 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 email address of the insurance agent. You must attach a copy of your certificate of insurance to the application.
  24. Check the appropriate box to indicate whether you have Worker’s Compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.
  25. Enter the first, middle, and last name of the pharmacist-in-charge at the business location.
  26. Enter the license number of the pharmacist-in-charge. Attach a legible copy of the license.
  27. Enter the driver’s license or state-issued identification number and the state of issuance of the pharmacist-in-charge named in number 25. Attach a legible copy to this application. The driver’s license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
  28. Enter the social security number of the pharmacist-in-charge named in number 25. (Optional—see Privacy Statement on page 7)
  29. Print the last, first, and middle name of the sole proprietor, partner, corporate officer or government official applying to the Department of Health Care Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
  30. Check the gender of the individual named in number 29.
  31. Enter the driver’s license or state-issued identification number and the state of issuance of the individual named in number 28. Attach a legible copy to this application.
  32. Enter the date of birth of the individual named in number 29.
  33. Enter the social security number of the individual named in number 29. (Optional—see Privacy Statement on page 7)
  34. An original signature of the individual named in number 29 is required. Also enter the title of the person signing the application. Include the city, state, and the date where and when the application was signed.
  35. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code 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.
- ✓ Remember to attach a legible copy of the following, if applicable:
- Fictitious Business Name Statement
  - TIN verification
  - Seller’s Permit
  - Licenses and certificates associated with business activities (as applicable):
    - Drug Enforcement Agency Controlled Substance Registration Certificate
    - California State Board of Pharmacy Permit
    - Bureau of Home Furnishings and Thermal Insulation License
  - Driver’s license or state-issued ID card for the pharmacist-in-charge
  - Signed Medi-Cal Disclosure Statement (DHCS 6207)
  - Signed Medi-Cal Provider Agreement (DHCS 6208)
  - Pharmacist-in-charge license
  - Driver’s license or state-issued identification card of person signing the application
  - Medicare enrollment verification
  - Successor Liability Agreement
  - Certificate of Liability Insurance
  - Certificate of Professional Liability Insurance
  - Proof of Worker’s Compensation Insurance
  - National Provider Identifier verification (CMS/NPPES confirmation letter)



# MEDI-CAL PHARMACY PROVIDER 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 997413  
 Sacramento, CA 95899-7413  
 (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.**

Enrollment action requested (check all that apply)	Date
--	------

New provider

For any of the following actions, include current Medi-Cal provider number:  
 \_\_\_\_\_ and/or NPI: \_\_\_\_\_

- Change of business address
- Additional business address
- New Taxpayer ID Number
- \*Change of ownership (per Title 22, CCR, Section 51000.6)
- \*Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
- \*Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
- \*Sale of assets (50 percent or more, per Title 22, CCR, Section 51000.30)
- New pharmacy permit

- 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 Title 22, CCR, 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 Title 22, CCR, 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 Title 22, CCR Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Indicate the change of ownership effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

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:    | <input type="checkbox"/> Limited liability company (LLC):               | <input type="checkbox"/> Other: _____          |
| Corporate number: _____                  | LLC number: _____   | <input type="checkbox"/> Nonprofit Corporation |
| State incorporated: _____                | State registered/filed: _____   | Type of nonprofit: _____                       |

1. Legal name of applicant or provider (as listed with the IRS)

2. Business name, if different	3. Business telephone number									
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Is this a fictitious business name?</td> <td style="width: 35%;">If yes, list the Fictitious Business Name Statement number</td> <td style="width: 40%;">Effective date</td> </tr> <tr> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> <td></td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: small;">(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)</td> </tr> </table>	Is this a fictitious business name?	If yes, list the Fictitious Business Name Statement number	Effective date	<input type="checkbox"/> Yes <input type="checkbox"/> No			(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)			(      )  _____
Is this a fictitious business name?	If yes, list the Fictitious Business Name Statement number	Effective date								
<input type="checkbox"/> Yes <input type="checkbox"/> No										
(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

7. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code
--------------------------	---------------	---------------

8. Taxpayer Identification Number (TIN) issued by the IRS (attach a legible copy of the IRS form)	9. Social security number (If sole proprietor not using a TIN, you must disclose this number.) (See Privacy Statement on page 7.)
---	---

10. California State Board of Pharmacy Permit number (attach a legible copy)	Expiration date	11. Medicare/Other NPI/Medicare Billing Number (attach a legible copy)	12. Seller's Permit number (attach a legible copy)
--	-----------------	--	--

13. Any local business license/permit numbers (attach legible copies)

14. Is your business open and conducting business in compliance with all state and local laws and ordinances regarding business licensing and operations?.....  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. 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 Title 22, CCR, Section 51476.).....  Yes  No

19. Do you sell, rent, or lease durable medical equipment, incontinence medical supplies and/or supply items? .....  Yes  No

If yes, do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operation and is readily identifiable? .....  Yes  No  
If no, please explain: \_\_\_\_\_

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, enter the following information for the warehouse:

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

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

20. 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. Percentages must total 100 percent. (Include licensure information of applicable business activities.) Please see instructions for computing percentages.

A.  Prescribed drugs \_\_\_\_\_%

Drug Enforcement Agency registration certification number	Effective/expiration dates (attach a legible copy of the certificate)	National Council for Prescription Drug Programs (NCPDP) number
---	---	--

B.  Beds\*       Rental       Sales (if the business sells AND rents beds, check both boxes.) \_\_\_\_\_%

C.  Wheelchairs\* \_\_\_\_\_%

\*Bureau of Home Furnishings and Thermal Insulation license:

If you rent beds, your license must bear a registry number. If it does not, please call the Bureau at (916) 574-0280 for instruction. If you checked bedding and wheelchairs, you must have a Furniture and Bedding License. Any questions must be directed to the Bureau at the above number.

Furniture and Bedding or Furniture Retailer License number (attach a copy): \_\_\_\_\_

Issuance date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

D.  Ostomy supplies (describe): \_\_\_\_\_%

E.  Oxygen/oxygen therapy equipment and supplies (describe): \_\_\_\_\_%

F.  Urinary catheters, bags, etc. (describe): \_\_\_\_\_%

G.  Orthotic/prosthetic appliances—limited to appliances listed in the provider manual and designated by double asterisks (\*\*) (describe) \_\_\_\_\_%

H.  Incontinence medical supplies (describe): \_\_\_\_\_%

**You must comply with Article 3.7 of the Welfare and Institutions Code. If you are not selling incontinence supplies, enter zero (0) in the percentage column.**

I.  Infusion equipment and supplies (describe): \_\_\_\_\_%

J.  Other (describe): \_\_\_\_\_%

**TOTAL** \_\_\_\_\_%

21. Does the applicant or provider provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? .....  Yes     No

If yes, does the applicant or provider have on staff, either as an employee or independent contractor, or does the applicant or provider 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

**22. 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

**23. Proof of Professional Liability Insurance—Applicant must attach a copy of the certificate of (malpractice) insurance for the Pharmacist-In-Charge (PIC) to this application.**

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 _____

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

**Information About the Pharmacist-In-Charge (PIC) at the Business Location**

25. Printed name (last) _____ (first) _____ (middle) _____	26. License number (attach a copy of license) _____
27. Driver's license or state-issued ID number and state of issuance (attach a legible copy) _____	28. Social security number ( <i>Optional</i> —see Privacy Statement below.) _____

**Information About the Individual Signing this Application**

29. Printed name of provider (last) _____ (first) _____ (middle) _____	30. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
31. Driver's license or state-issued identification number and state of issuance (attach a legible copy) _____	32. Date of birth _____
33. Social security number ( <i>Optional</i> —see Privacy Statement below.) _____	

34. 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.

Signature of provider _____	Title _____
-----------------------------	-------------

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

35. Notary Public—Please see number 35 in the instructions for who must notarize must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

**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.