



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



SANDRA SHEWRY
Director

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

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

PLEASE NOTE: Effective May 23, 2007, applicants and providers will be 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 (NPPES) 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.

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* (DHS 6209, rev. 3/07 – DHCS 6209, rev. 7/07) form. 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 Title 22, California Code of Regulations (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. 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*.

Enrollment forms are available at www.medi-cal.ca.gov or by contacting the Telephone Service Center at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site 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 above or via e-mail at PEDCorr@dhcs.ca.gov. In order to submit claims electronically, providers must request a submitter number by completing the *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, under "Provider Resources", "Forms", then "Billing."

Provider Enrollment Division

Enclosures

(Revised 7/07)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

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) 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 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.

To request consideration for Preferred Provider Status, check the box and include all required documentation pursuant to the Provider Bulletin dated February 2005. To obtain a copy of this Bulletin, you can go to the Medi-Cal Web site, Provider Enrollment link to Preferred Provider Status. Only those complete applications, submitted with all qualifying documentation included, will be processed for preferred provider status.

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 a new Medi-Cal provider number 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 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.

"Licensed Primary Care Clinic Provider" or "Facility-Based Provider" - If you check this box you must comply with all the enrollment requirements of the applicable Provider Bulletin. To obtain a copy of the applicable bulletin, you can go to the Medi-Cal Web site, Provider Enrollment link to Provider Bulletins.

"Reactivate provider number"— check if you have previously had an active provider number and you want to re-establish yourself as a Medi-Cal provider.

"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 current 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 identifies 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.
 - 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 Welfare and Institutions Code Section 14043.15(b)(2). See the ‘Facility-Based Provider’ bulletin on the “Provider Enrollment Division” page of the Medi-Cal Website (www.medi-cal.ca.gov) for the requirements to qualify for that exception.
 - b. Check whether the business address is a licensed primary care clinic as defined by Section 1204(a) of the Health and Safety Code. See the Clinic Based Provider Bulletin on the “Provider Enrollment Division” page of the Medi-Cal Website (www.medi-cal.ca.gov) for the additional requirements.
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 the medical license number(s) of the applicant or provider. Attach a legible copy of the license. List the specialty(ies) and indicate if board certified or eligible.
8. Enter other NPI registered with other carriers including, but not limited to Medicare. Attach copies of CMS/NPPES confirmation letter for each. Providers not eligible to receive an NPI (atypical providers) should submit a Medicare billing number.
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. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
11. 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)
12. Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA certificate. The name and address on the certificate must match the name and address as entered in numbers 1 and 4.
13. Enter the State Laboratory License/Registration number. Attach a legible copy of the license/registration.
14. Enter the driver’s license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application.
15. Enter the date of birth of the individual named in number 1.
16. Check the gender of the individual named in number 1.
17. Enter any local business license or permit numbers for any city and/or county where you conduct your business activities and attach copies to the application. If this does not apply to you, enter N/A.
18. Enter the Seller’s Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller’s Permit. If this does not apply to you, enter “N/A.”

19. Enter the requested information. Attach to this application a legible copy(ies) of applicant's or provider'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 or provider's current Certificate of Insurance for Professional Liability Insurance (malpractice insurance) to this application.
21. 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.
22.
 - a. Enter information on whether the applicant or provider has 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), address(es), and telephone number(s) of the hospital(s) where current privileges have been granted. If the applicant or provider has privileges at more than one hospital, attach an additional sheet supplying all of the requested information if needed.
 - b. Enter information on whether the applicant or provider has had privileges at any hospital(s) that were ever suspended or revoked. If so, provide 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.
 - c. Enter information on whether the applicant or provider has had privileges at any hospital(s) that were voluntarily resigned or otherwise surrendered. If so, provide 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.
23. Pursuant to W&I Code, Section 14043.15(b)(2), if you are providing services solely in a hospital or clinic (facility) at the location(s) listed here and are requesting one provider number, please complete this certification. A list of all hospitals or clinics where services are provided must be attached to the application.
24. Print name of the physician signing the application. An original signature of the individual is required. Include the city, state, and the date where and when the application was signed.

✓ Remember to attach a legible copy of the following, if applicable:

- Driver's license or state-issued identification card
- TIN verification
- CLIA Certificate
- Medical license(s)
- Fictitious Business Name Statement/Permit
- State Laboratory License/Registration
- Signed Medi-Cal Disclosure Statement (DHCS 6207)
- Certificate(s) of Insurance for Liability and Professional Liability Insurance and Worker's Compensation Insurance
- Local business license(s) or permit(s)
- Seller's Permit
- Successor Liability Agreement
- National Provider Identifier verification (CMS/NPPES confirmation letter)



MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

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

Preferred provider status requested pursuant to Welfare and Institutions Code, Section 14043.26(c). All qualifying documentation and cover letter attached.

- **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):

New provider

Date _____ / _____ / _____

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)
- Licensed Primary Care Clinic Based Provider or Facility Based Provider
- Reactivate Provider Number

- 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):

- Sole proprietor (unincorporated)
- Partnership (attach legible copy of agreement)
- Government
- Nonprofit Corporation—Type of nonprofit: _____
- Professional Medical Corporation—corporate number: _____
- 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?

Yes No

If yes, list the Fictitious Business Name Permit number

Effective date

(Attach a legible copy of the Fictitious Business Name Permit issued by the Medical Board.)

4. Business address (number, street)

City

County

State

Nine-digit ZIP code

a. If you are applying as a facility-based provider, complete this section:

This address is a licensed hospital/health facility. Yes No

Check the option that applies:

All services are provided at this location.

I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all business addresses where the provider renders services.

b. If you are applying as a clinic-based provider, complete this section:

This address is a licensed hospital/health facility. Yes No

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. Medical license number (attach a legible copy)

List specialty(ies)

Board certified YES NO

Board eligible

8. Medicare/Other NPI/Medicare billing number (attach a legible copy)

9. Primary Taxonomy Code

Taxonomy Code

Taxonomy Code

10. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form.)

11. Social security number—if Sole Proprietor not using a TIN, you must disclose this number (See Privacy Statement on page 7.)

23. **Self certification and statement of intent to employ a separate billing method for hospital/clinic-based physician.**
(To be completed only if the practice location is a licensed health facility.)

The undersigned hospital/clinic and physician agree to the following requirement for enrollment as a hospital/clinic-based physician. It is agreed and understood by _____ and

(Physician Name)

_____ that there shall be no duplicate

(Hospital/Clinic Name)

billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the physician to Medi-Cal beneficiaries shall be billed using the physician's provider number. To ensure the money paid to the physician is not included in the cost settlement process, we recommend that the hospital/clinic set up a separate nonreimbursable cost center to account for all clinic-related payments. Additionally, the hospital/clinic should keep track of overhead support costs related to the reimbursable costs. At year end the costs related to the guarantee to the physician's clinical billings should be easily identifiable by our audit staff on your cost report. If it appears impossible/impractical for you to set up a separate cost center, then the direct cost related to physician clinical activities at a minimum should be eliminated from the trial balance cost via an A-8 adjustment on your cost report. This method of billing will become effective for services performed on or after _____ . We declare under penalty of perjury

(Date)

_____ under the laws of the State of California that the foregoing information is true and correct to the best of our knowledge.

Hospital/clinic name

Address (number, street)

City

State

Nine-digit ZIP code

Print name of authorized hospital/clinic representative

Authorized hospital/clinic representative signature

Date

Print physician name

Business name

Physician signature

Date

Pursuant to W&I Code, Section 14043.15(b)(2), my practice is solely at the location(s) listed here, for which one provider number is requested. A list of all qualifying addresses must be attached to the application.

24. **I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments are true, accurate, and complete to the best of my knowledge and belief.**

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Care Services ("DHCS"), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider in the Medi-Cal program.

I agree to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services ("Secretary"). I further agree to provide if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Physician from participation in the Medi-Cal program. Physician will be reimbursed for reasonable copy costs as determined by DHCS, AG and/or Secretary.

I also agree that DHCS, AG and/or Secretary may make unannounced visits to Physician, at any of Physician's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS, AG and/or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of physician from participation in the Medi-Cal program.

Printed name of physician (last) (first) (middle)

Signature of the physician

Executed at: _____, _____ on _____
(City) (State) (Date)

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, (916) 323-1945.