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 question, 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 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 in 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 which 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 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.

"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.

"Deletion of one or more rendering providers resulting in one remaining rendering provider"—check if the applicant only has one remaining rendering provider after the deletion of one or more of its rendering providers.

"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 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. 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 Welfare and Institutions Code Section 14043.15(b)(2). See the 'Facility-Based Provider' bulletin at the Medi-Cal program Website (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. 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).

8. Enter any NPI registered with other carriers including, but not limited to Medicare. Attach CMS/NPPES verification letter for each. Providers not eligible to receive an NPI (atypical providers) should submit a Medicare billing number.

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

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

11. 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, Dentists, Registered Dental Hygienist Alternative Practice).

12. If this is a physician provider group, or dentist provider group, list the specialty(ies).

13. List the name, license number, social security number, and date of birth of all ***new*** rendering providers in the provider group. Attach additional sheets, if necessary. An individual application, disclosure statement, and provider agreement are required for each new rendering provider in the provider group. The provider agreement is not required for physicians applying for enrollment as a rendering provider in a provider group. Provision of the social security number is optional (see Privacy Statement on page 6).

14a. 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.

14b. 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.

14c. 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.

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

16. 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.

17. 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.

18. Enter the facility's health care license number, its effective date and its expiration date. 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 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 worker's compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.
22. If you are providing services in a licensed hospital or clinic (facility), please complete this certification.
23. "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.
24. Check the gender of the individual named in number 23.
25. 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.
26. Enter the date of birth of the individual named in number 23.
27. Enter the social security number of the individual named in number 23. Provision of the social security number is optional (see Privacy Statement on page 6).
28. An original signature of the individual named in number 23 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.
29. 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 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:

- ❒ 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 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 Worker's Compensation Insurance
- ❒ Medicare enrollment verification
- ❒ Successor Liability Agreement
- ❒ National Provider Identifier verification (CMS/NPPES verification letter)

MEDI-CAL PROVIDER GROUP APPLICATION

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.
- For Medi-Cal 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

For Denti-Cal return completed forms to:

Medi-Cal Dental Program
Provider Enrollment Division
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

- ***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.***

FOR STATE USE ONLY

Enrollment action requested (check all that apply)

Date

❒ New provider

For any of the following actions, include current group 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 or transfer of assets (50 percent or more) (per Title 22, CCR, Section 51000.30)
❒ Deletion of one or more rendering providers resulting in one remaining rendering provider.

❒ 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
❒ Partnership
❒ Government entity
❒ Corporation: Corporate number: _____ State incorporated: _____
❒ Limited Liability Company (LLC): LLC number: _____ State registered/filed: _____
❒ Nonprofit Corporation Type of nonprofit: _____
❒ Other: _____

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

2. Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date	3. Provider group telephone number ( )
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)		

4. Provider group business address (number, street)	City	County	State	Nine-digit ZIP code

a. ❒ 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.

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. Taxpayer Identification Number (TIN) or social security number (Attach a legible copy of the IRS form)	8. Medicare/Other NPI (Attach a legible copy)	9. Seller's Permit number (attach a legible copy)

10. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code

11. Type of provider group	12. If physician(s) or dentist(s), list specialty(ies)

13. 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

14. **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 / Nine-digit ZIP code
Name of physician	Name of Hospital	Telephone number ( )
Address (number, street)	City	State / Nine-digit ZIP code

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 / Nine-digit ZIP code

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 / Nine-digit ZIP code

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

18. Facility health care license number (attach legible copy)	License effective date	License expiration date

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 of policy (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 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

21. 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:

_____

22. SELF CERTIFICATION AND STATEMENT OF INTENT TO EMPLOY A SEPARATE BILLING METHOD FOR HOSPITAL BASED PROVIDER GROUPS. (TO BE COMPLETED ONLY IF THE PRACTICE LOCATION IS A LICENSED HEALTH FACILITY.)

The undersigned hospital/clinic and provider group agree to the following requirements for enrollment as a Medi-Cal facility based provider group. It is agreed and understood by _____ and
(Provider group name)

_____
(Hospital/clinic name)

that there shall be no duplicate billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the group to Medi-Cal beneficiaries shall be billed using the provider group number. To ensure the money paid to the group is not included in the cost settlement process, we recommend that the hospital set up a separate nonreimbursable cost center to account for all licensed health facility-related payments. Additionally, the hospital should keep track of overhead support costs related to the reimbursable costs. At year-end the costs related to the guarantee to group clinical billings should be easily identifiable by our audits 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 the group's 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 representative signature		Date
Print provider group name	Print name of authorized provider group representative		
Authorized provider group representative signature			Date

Information About Individual Signing This Application

23. Printed name of provider (last)	(first)	(middle)	24. Gender ❒ Male ❒ Female
25. Driver's license or state-issued ID number and state of issuance (attach a legible copy)	26. Date of birth	27. Social security number (***Optional***—see Privacy Statement below.) ___ ___ ___ – ___ ___ – ___ ___ ___ ___	

28. **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)

29. Notary Public — Please see instructions under number 29 for who 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 or for Denti-Cal, contact (800) 423-0507.