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

TOBY DOUGLAS
*DIRECTOR*

EDMUND G. BROWN JR.
*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:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997412
Sacramento, California, 95899-7412

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

**PLEASE NOTE:** Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation 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 Department of Health Care Services (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* form (DHCS 6209, rev. 01/13). 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 *California Code of Regulations* (CCR), Title 22, 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* (DHCS 6217, rev. 02/08).

Enrollment forms are available at www.medi-cal.ca.gov or by contacting the Telephone Service Center (TSC) at (800) 541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our website 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 on the previous page or via email 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. 03/12), available on the Medi-Cal website at www.medi-cal.ca.gov, by clicking on the "Forms" link in the "Featured" area, and then selecting the form under the "Billing" category.

Provider Enrollment Division

Enclosures (01/13)

# INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL NONPHYSICIAN MEDICAL PRACTITIONER AND LICENSED MIDWIFE 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 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) 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 California Code of Regulations (CCR), Title 22, Section 51000.50.**

**You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for each National Provider Identifier (NPI) submitted with your application package. You may not submit an NPI for use in Medi-Cal billing unless that NPI is appropriately registered with CMS and is in compliance with all NPI requirements established by CMS at the time of submission.**

Enrollment action requested (check all that apply). Enter the date you are completing the application.

"Add new"—the Nonphysician Medical Practitioner or Licensed Midwife is not currently enrolled in the Medi-Cal program under the listed Employing Provider.

"Delete"—you no longer wish to be enrolled as a practitioner under the listed Employing Provider.

"Change"—you need to change information previously submitted to the Department.

"Continued Enrollment"—you are currently enrolled in the Medi-Cal program and would like to continue participation. (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 CCR, Title 22, Section 51000.55)

**Note:** If you are enrolling as an individual provider do not submit this application form. Please submit a MEDI-CAL PROVIDER APPLICATION (DHCS 6204), a MEDI-CAL DISCLOSURE STATEMENT (DHCS 6207) and a MEDI-CAL PROVIDER AGREEMENT (DHCS 6208).

A. **Nonphysician Medical Practitioner or Licensed Midwife Information**

1. "Legal name"—enter the name listed with the Internal Revenue Service (IRS).
2. Enter driver's license number or state-issued identification card number and state of issuance. Attach a legible copy.
3. Enter the Nonphysician Medical Practitioner or Licensed Midwife's National Provider Identifier. Attach a copy of the CMS/NPPES confirmation.
4. Enter the nine-digit social security number (optional) or Taxpayer Identification Number (TIN) and attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification). See Privacy Statement on page 7.
5. Enter the date of birth of the individual listed in number 1.
6. Check the gender of the individual listed in number 1.
7. Enter the practitioner's or midwife's license or certification number and attach a legible copy to the application.
8. Enter the date the practitioner was first employed by the employing provider identified on this application form. Attach verification of employment.
9. Enter the effective date of the license/certification number.
10. Enter the expiration date of the license/certification number.
11. Enter the maximum number of hours per week the practitioner works at the business address identified in number 17.
12. Enter the number of hours per week the practitioner is supervised at this business address by the supervising physician identified in number 23.
13. Nurse Practitioners only—enter the duration of the nurse practitioner training program.

14. Nurse Practitioners only—enter the name of the school at which the nurse practitioner training program was completed.
15. List taxonomy codes associated with your NPI. Attach additional sheets if necessary.

B. **Employing Provider Information**

16. "Legal name"—enter the name of the individual or the business name of the entity listed with the IRS. Indicate if this is a business entity.
17. Enter the employing provider's business address including the street address, city, state, and ZIP code at which the practitioner will render services.
18. Enter the medical license number of the employing provider, if applicable. Attach a legible copy of the license.
19. Enter the employing provider's National Provider Identifier for the address identified in number 17.
20. Check the box for the type of facility identified as the business address identified in number 17.
21. Check the box for the primary type of service delivered at the business address identified in number 17.
22. "Business telephone number"—enter the primary business telephone number used at the business address identified in number 17. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the business telephone number.

C. **Supervising Physician Information**

23. "Legal name"—enter the supervising physician's name listed with the IRS.
24. Enter the supervising physician's medical license number(s). Attach a legible copy.
25. Enter the supervising physician's National Provider Identifier.
26. Enter the supervising physician's driver's license number or state-issued identification number and state of issuance. Attach a legible copy.
27. Enter the telephone number at which the supervising physician can be reached.
28. Enter the date of birth of the individual listed in number 23.
29. Check the gender of the individual listed in number 23.
30. Enter the type of practice or specialty of the supervising physician.
31. List the name(s) and practitioner type of any other Nonphysician Medical Practitioners or Licensed Midwife currently being supervised at this and other locations by the supervising physician identified in number 23. List the maximum number of hours the practitioner works each week.

**NOTE:** The Business and Professions Code (Articles 2 and 2.5 of Chapter 6 and chapter 7.7) limits the number of practitioners a single primary care physician is allowed to supervise. It is the responsibility of the supervising physician to ensure that the number of practitioners being supervised does not exceed that limit. One supervising physician is limited to supervising a maximum of four practitioners at one time in any combination as long as the limit for each practitioner type established in the Business and Professions Code is not exceeded. Additional limits are defined in Welfare and Institutions Code, Section 14043.47, that states in relevant part that a physician doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a physician provider in a group may not be enrolled at more than three business addresses unless there is a ratio of at least one physician providing supervision for every three locations.

D. **Additional Information**

32. If the Nonphysician Medical Practitioner or Licensed Midwife works for no other Medi-Cal providers, check the "None" box. Otherwise, enter the name, provider number, business address, and maximum hours worked per week for each additional Medi-Cal provider for whom the Nonphysician Medical Practitioner or Licensed Midwife works. The Nonphysician Medical Practitioner or Licensed Midwife must be enrolled at each location.

E. **Information about person signing the application for Employing Provider**

33. "Legal Name and Title"—enter the signing person's name listed with the IRS and their title at the Employing Provider.
34. Enter the signing person's driver's license number or state-issued identification number and state of issuance. Attach a legible copy.
35. Enter the signing person's social security number. (This field is optional—see Privacy Statement on page 7)
36. Enter the date of birth of the individual listed in number 33.
37. Check the gender of the individual listed in number 33.

F. **Insurance Information**

38. 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 e-mail address of the insurance agent. You must also attach a copy of your certificate of insurance to the application.

G. **Nonphysician Medical Practitioner or Licensed Midwife Signature**

39. Print the name of the Nonphysician Medical Practitioner or Licensed Midwife. An original signature is required. Include when and where the application was signed.

H. **Employing Provider Signature**

40. Print the name of the employing provider. An original signature of the employing provider is required. Include when and where the application was signed.

    If the employing provider is an individual sole proprietor or partner, the employing provider is required to personally sign the application. If the employing provider is a professional corporation, a governmental entity or non-profit organization, then a corporate officer, or an official representative of the governmental entity or non-profit organization who has the authority to legally bind an applicant seeking enrollment, may sign. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine who has the authority to sign this application.**

I. **Supervising Physician Signature**

41. Print the name of the supervising physician. An original signature of the supervising physician is required. Include the date when the application was signed.

**Notarization**

42. 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.

**Contact Information**

43. To assist in the timely processing of the application package, enter the name, e-mail address, and telephone number of the individual who can be contacted by Provider Enrollment staff to answer questions regarding the application package. Failure to include this information may result in an application being returned deficient for an item that an applicant could readily send by fax or explain over the telephone.

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

- ☐ Nonphysician Medical Practitioner or Licensed Midwife's and supervising physician's driver's license or state-issued identification card(s)
- ☐ Nonphysician Medical Practitioner or Licensed Midwife's license or certification
- ☐ Employing provider's medical license
- ☐ Supervising physician's medical license
- ☐ Completed Medi-Cal Disclosure Statement (DHCS 6207)
- ☐ Completed Medi-Cal Provider Agreement (DHCS 6208)
- ☐ Certificate of insurance for practitioner
- ☐ Verification of practitioner's employment
- ☐ Driver's license or state issued identification card of person signing for employing provider
- ☐ National Provider Identifier verification (CMS/NPPES confirmation)

# MEDI-CAL NONPHYSICIAN MEDICAL PRACTITIONER AND LICENSED MIDWIFE 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.
- Return completed forms to: Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997412
  Sacramento, CA 95899-7412
  (916) 323-1945

***Do not use staples on this form or on any attachments.***

***Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.***

***FOR STATE USE ONLY***

Action requested (check all that apply) | Date

**Add new:**
- ☐ Certified Nurse Midwife (NM)
- ☐ Licensed Midwife (LM)
- ☐ Nurse Practitioner (NP)
- ☐ Physician's Assistant (PA)
- ☐ Other (specify): _____

**Delete:**
- ☐ NM
- ☐ LM
- ☐ NP
- ☐ PA
- ☐ Other (specify): _____

**Change:**
- ☐ Supervising physician when employing provider remains the same (complete Sections A, C, D)
- ☐ Hours of supervision per week (complete all sections)
- ☐ Maximum hours per week (complete all sections)

☐ **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.)

## A. Nonphysician Medical Practitioner or Licensed Midwife Information

1. Legal name (as listed with IRS)

2. Driver's license number or state-issued ID and state of issuance (attach a legible copy)

3. Provider Number (NPI—attach CMS/NPPES confirmation)

4. Social security number (See Privacy Statement on page 7) or Taxpayer Identification Number (TIN) (attach a legible copy)

5. Date of birth

6. Gender ☐ Male ☐ Female

7. Practitioner's or midwife's license/certification number (attach a legible copy)

8. Date first employed by employing provider (attach verification of employment)

9. License/certification effective date

10. License/certification expiration date

11. Maximum work hours per week at this business address

12. Hours of supervision per week at this business address by the Supervising Physician identified in number 23

13. Duration of training program (Nurse Practitioner only)

14. School that provided training (Nurse Practitioner only)

15. Primary Taxonomy Code | Taxonomy Code | Taxonomy Code

## B. Employing Provider Information

16. Legal name (as listed with IRS) — Check if business entity ☐

17. Business address (number, street) | City | State | Nine-digit ZIP code

18. Medical license number (if applicable, attach a legible copy)

19. Provider number (NPI)

20. Type of healthcare practice at primary business address (check one)

☐ Skilled Nursing Facility ☐ Hospital Outpatient Department ☐ Physician's Office
☐ Intermediate Care Facility ☐ Outpatient Clinic ☐ Other: _____

21. Primary type of service rendered

☐ Internal Medicine ☐ Pediatrics ☐ General
☐ OB/GYN ☐ Family planning ☐ Other: _____

22. Business telephone number

( )

## C. Supervising Physician Information (Must be an enrolled Medi-Cal provider)

23. Legal name (as listed with IRS)

| 24. Medical license number (attach a legible copy) | 25. Provider number (NPI) |
|---|---|
| 26. Driver's license number or state-issued ID and state of issuance (attach a legible copy) | 27. Contact telephone number ( ) |
| 28. Date of birth | 29. Gender ☐ Male ☐ Female |

30. Type of practice/specialty

31. Nonphysician Medical Practitioners or Licensed Midwives Currently Supervised (all locations)

| Practitioner Name | Practitioner Type (NM, LM, NP, PA, Other) | Maximum Hours Worked Per Week |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## D. Additional Information

32. Indicate below other Medi-Cal provider(s) for whom the practitioner currently works

☐ None

| Information About Other Employing Providers | Business Address (Street, City, State, ZIP Code) | Maximum Hours Worked Per Week |
|---|---|---|
| Name: | | |
| Provider number (NPI): | | |
| Name: | | |
| Provider number (NPI): | | |
| Name: | | |
| Provider number (NPI): | | |
| Name: | | |
| Provider number (NPI): | | |

## E. Information about Person Signing Application for Employing Provider

33. Legal name (as listed with IRS) and Title

| 34. Driver's license number or state-issued ID Number and state of issuance (attach a legible copy) | 35. Social Security number (optional-see privacy statement on page 7) |
|---|---|
| 36. Date of birth | 37. Gender ☐ Male ☐ Female |

## F. Insurance Information

38. Proof of Professional Liability Insurance-Nonphysician Medical Practitioner or Licensed Midwife 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 |
|---|---|---|

## G. Nonphysician Medical Practitioner or Licensed Midwife Signature

39. I declare under penalty of perjury under the laws of the State of California that the foregoing information and all attachments are true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, 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. I understand that it is my responsibility to read the manual and its updates.

Print Name of Nonphysician Medical Practitioner or Licensed Midwife (last) (first) (middle)

Signature of Nonphysician Medical Practitioner or Licensed Midwife

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

## H. Employing Provider Signature

40. I declare under penalty of perjury under the laws of the State of California that the foregoing information and all attachments are true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, 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. I understand that it is my responsibility to read the manual and its updates. I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

Print Name of Employing Provider signing this application (last) (first) (middle)

Signature of person authorized to legally bind the Employing Provider

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

## I. Supervising Physician Signature

41. I declare under penalty of perjury under the laws of the State of California that the foregoing information and all attachments are true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, 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. I understand that it is my responsibility to read the manual and its updates.

Print Name of Supervising Physician (last) (first) (middle)

**Signature of Supervising Physician**

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

42. Notary Public — Please see instructions under number 42 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

43. Contact Person's Information

☐ Check here if you are the same person identified in item 1. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (Last) (First) (Middle)

| Title/Position | E-mail address | Telephone number |
|---|---|---|
| | | ( ) |

## 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) and California Code of Regulations, Title 22, Section 51536. 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 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.