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INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED PROVIDERS

DO NOT USE staples on this form as well as on any attachments.
DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a rendering provider in the Medi-Cal program. **If you are completing this form, you will not need to submit a disclosure statement and provider agreement.** A rendering provider is "an individual provider who renders healthcare services, or provides goods, supplies, or merchandise, as a member of a provider group and uses the group number to bill the Medi-Cal program." Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

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 2004 or 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 with a preferred provider status.

Action requested (check [✓] all that apply). Enter the date you are completing the application.

"New rendering physician/allied provider"—the applicant is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

Provider Type: Check (✓) the appropriate provider type box for which you are applying to render services for the Medi-Cal program.

1. "Legal name"—enter the name listed with the Internal Revenue Service (IRS).
2. Enter the date of birth of the individual named in number 1.
3. Check (✓) the gender of the individual named in number 1.
4. Enter the social security number of the individual named in number 1. (This field is ***optional***.)
5. 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. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
6. Enter the license certificate number, or other approval to provide health care, of the applicant. Attach a legible copy of the license, certificate, or approval. Enter the effective date of the license certificate number, or other approval. Enter the expiration date of the license certificate number, or other approval. If a physician, list the specialty(ies) and indicate if board-certified or -eligible.
7. "Business address"—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.
8. "Business telephone number"—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.
9. "Contact person"—enter the name of the person who can be contacted regarding the application package.
10. "Contact telephone number"—enter the phone number of the contact person.
11. "Contact e-mail address"—enter the e-mail address of the contact person.
12. "Residence address"—the residence address of the applicant listed in number 1.

Disclosure Information

1. Check (✓) the appropriate boxes and explain any "yes" answers.
2. Check (✓) the appropriate boxes and explain any "yes" answers.
3. Check (✓) the appropriate boxes and explain any "yes" answers.
4. Check (✓) the appropriate box and list all Medi-Cal numbers, if appropriate, as well as the state(s) and name(s) applivcant or provider used when participating in another state Medicaid program and all applicable provider numbers. If you cannot provide the numbers, please explain.
5. Check (✓) the appropriate box and, if applicable, provide the effective date(s) of suspension(s) date(s) of reinstatement and Medicare and/or Medicaid provider number.

6. Check (✓) the appropriate box and, if applicable, list the state(s) where applicant's or provider's license, certificate, or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
7. Check (✓) the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach a written confirmation that professional privileges have been restored.
8. Check (✓) the appropriate box and, if applicable, list the requested information.
9. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid, and all other federal and state health health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). Submit copies of all documents pertaining to the arrangement including terms and conditions.
10. "Residence Address"—the residence address of the applicant listed in number 1.

Provider Agreement

29. 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
- ☐ License certificate

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MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED PROVIDERS

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: California Department of Health Services
  Provider Enrollment Branch
  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 as well as 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 rendering physician/allied provider

Date

Provider Type (check one)

☐ Audiologist ☐ Chiropractor ☐ Physician ☐ Psychologist

☐ Certified Nurse Midwife ☐ Optometrist ☐ Podiatrist ☐ Other: _____

☐ Certified Registered Nurse Anesthetist ☐ Orthotist ☐ Prosthetist

1. Legal name of applicant (last name)	(first name)	2. Date of birth	3. Gender

4. Social security number	5. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

6. Professional license/certified certificate number (attach legible copy)	License effective date	License expiration date	List specialty(ies)—Physician's only	Yes	No
			Board-certified	☐	☐
			Board-eligible	☐	☐

7. Business address (office/hospital) (number, street)	City	County	State	ZIP code

8. Business telephone number	9. Contact person's name	10. Contact person's telephone number	11. Contact person's email address
( )		( )	

DISCLOSURE INFORMATION

Respond to the following questions:

1. ***Within ten years of the date of this statement***, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____

2. ***Within ten years of the date of this statement,*** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No

   If yes, provide the date of final judgment (mm/dd/yyyy): _____

3. ***Within ten years of the date of this statement,*** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No

   If yes, provide the date of the settlement (mm/dd/yyyy): _____

4. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No

   If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	PROVIDER NUMBER(S)

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5. Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No

If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. Has the individual license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been suspended or revoked? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

7. Have you, the applicant/provider, ***ever*** lost or surrendered your license, certificate, or other approval to provide health care while a disciplinary hearing was pending? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

8. Has the license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

9. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐ N/A

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
$			
$			

10. Residence address (number, street)	City	State	ZIP code

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PROVIDER AGREEMENT

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 Services, Provider Enrollment Branch. 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.

Printed legal name of applicant (last) (first) (middle)

Original signature of applicant

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

Notary Public:

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 notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application 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 California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from 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 Branch, Payment Systems Division, Sacramento, CA, (916) 323-1945.