INSTRUCTIONS FOR COMPLETION OF THE DRUG MEDI-CAL SUBSTANCE USE DISORDER MEDICAL DIRECTOR/ LICENSED SUBSTANCE USE DISORDER TREATMENT PROFESSIONAL/ SUBSTANCE USE DISORDER NONPHYSICIAN MEDICAL PRACTITIONER APPLICATION//AGREEMENT/ DISCLOSURE STATEMENT

This application is for the <u>sole purpose of enrollment of the substance use disorder medical director, licensed substance use disorder treatment professional, or substance use disorder nonphysician medical practitioner.</u> This type of enrollment <u>does not</u> allow the Medi-Cal program to reimburse the applicant/provider for services provided.

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 or 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 (California Code of Regulations, Title 22, Section 51000.55) solely as a substance use disorder medical director, substance use disorder professional, or substance use disorder nonphysician medical practitioner in the Drug Medi-Cal program. Applicant/Provider must also provide additional information and documentation. Applicant/Providers may be subject to an onsite inspection and to unannounced visits prior to enrollment or approval of continued enrollment in a program. Additional information can be found on the following Medi-Cal Website (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

Omission of any information on this form, or the failure to provide required documentation or signature in ink on any of these documents may result in denial of the application as provided in California Code of Regulations (CCR). Title 22, Section 51000.50.

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

"Provider Number (NPI)" – enter your NPI. For substance use disorder medical directors, substance use disorder nonphysician medical practitioners, and licensed substance use disorder treatment professionals a Type 1 NPI is required.

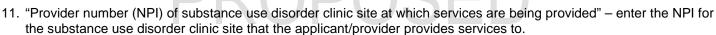
"Provider Type" - Enter the provider type. See list in CCR, Title 22, Section 51051.

"Date" – enter the date you are completing the application.

"Enrollment Action Requested" - mark the appropriate box.

- I. Identifying Information
 - 1. "Legal Name" enter the applicant's/provider's legal name (last, first and middle) as it appears on the professional license
 - 2. "Date of Birth" enter the date of birth of the applicant/provider.
 - 3. "Gender" enter the gender of the applicant/provider.
 - 4. "Residence address" enter the residence address of the individual listed in Item 1.
 - 5. "Mailing address" enter the address where correspondence may be sent to the applicant/provider directly.
 - "Social Security number" enter the social security number of the applicant/provider.
 - 7. Enter the driver's license or state-issued identification card number and state of issuance of the applicant/provider. Attach a current and legible copy to the application. The driver's license or state-issued identification card number must have been issued within the 50 United States or the District of Columbia.
 - 8. Enter the professional license, certificate number, or other permit or approval to provide health care, of the applicant/provider. Attach a current and legible copy of the license, certificate, permit or approval. Enter the **effective date** and **expiration date** of the license, certificate, permit or approval. List specialty(ies), if applicable.
 - 9. "Business address" enter the business location including the street name and number, room or suite number or letter, city, State and nine-digit ZIP code where services are provided. A post office box or commercial box is not acceptable.
 - 10. "Name of entity at which services are being provided" enter the legal name as listed with the Internal Revenue Services for the applicant or provider.

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- 12. If the applicant/provider is a substance use disorder medical director, list the name(s), business address, and provider number (NPI) of any other substance use disorder clinic currently being supervised by the applicant/provider.
- 13. "Proof of professional liability insurance" enter the name of the insurance company, date policy issued, expiration date of policy, insurance agent's name, and telephone number of the insurance agent. You must also attach a current and legible copy of your certificate of insurance to the application.

II. Disclosure information

- 1. Check the appropriate box and provide the date of conviction if applicable.
- 2. Check the appropriate box and provide the date of the final judgment if applicable.
- 3. Check the appropriate box and provide the date of settlement if applicable.
- 4. Check the appropriate box and list all provider numbers, if applicable, as well as the state(s) and name(s) applicant or provider used when participating in another state Medicaid program. If you cannot provide the numbers, please explain.
- 5. Check the appropriate box and list all provider numbers, if applicable, provide the effective date(s) of suspension(s), dates(s) of reinstatement, and Medi-Cal, Medicare and/or Medicaid NPIs or provider number(s). Attach verification of reinstatement to the applicable program.
- 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 services was suspended or revoked, the action(s) taken, and the effective date(s) of those action(s). 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, the action(s) taken, and the effective date(s) of those action(s). Attach a written confirmation from the licensing authority that professional privileges have been restored.
- 8. 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 disciplined by any licensing authority, action(s) taken and the effective date(s) of those action(s). Attach a written confirmation of the licensing authority decision(s) including any terms and conditions for each decision.
- 9. List below fines/debts due and owing by applicant or 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 arrangement(s) have been made to fulfill the obligations(s). Submit copies of all documents pertaining to the arrangement(s) including terms and conditions. If applicable, Check N/A box.

III. Provider Agreement

Print legal name of the applicant/provider signing the application. An original signature of the applicant/provider is required. Include the city, state, and the date where and when the application was signed. Include the applicant's/provider's e-mail address and contact phone number.

Contact Person's Information:

To assist in the timely processing of the application package, enter the name, title/position, email address and telephone number or cellular phone 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 the application package being returned deficient for item(s) that an applicant/provider can readily provide by fax or telephone.

Attach :	a legible copy of the following:
	Driver's license or state-issued identification card
	Professional License Certificate (Pocket License)
	National Provider Identifier verification (CMS/NPPES confirmation)
	Professional liability insurance
Attach	the additional required documents, if applicable:
	Verification of reinstatement
	Written confirmation from licensing authority that your professional privileges have been restored.
	Written confirmation from the licensing authority that includes the terms and conditions of the disciplinary action
	taken and the status of the licensure.
	Copies of all documents pertaining to arrangements to fulfill all fines/debts due and owing to any Medicare, Medicaid or any other federal, state or local health care program.

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Department of Health Care Services





Drug Medi-Cal Substance Use Disorder Medical Director/ Licensed Substance Use Disorder Treatment Professional/ Substance Use Disorder Nonphysician Medical Practitioner Application/Agreement/Disclosure Statement

mportant: Read all instructions before completing the Type or print clearly, in ink. If you must make corrections, please line 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 attachment on the leave any questions, boxes, lines, etc. bla	through	n, date, a		ı.				FOR	STATE U	JSE ONLY
Provider Number (NPI):		er Type:					Date	/	/	
 ENROLLMENT ACTION REQUESTEI	<u> </u>									
☐ New Substance Use Disorder Medical Director☐ New Substance Use Disorder Nonphysician Medic☐ New Licensed Substance Use Disorder Treatment	cal Practi		☐ Continued Enr							
I. IDENTIFYING INFORMATION						0. D. L.	£1.5.41			0.0
I. Legal name of applicant/provider (as it appears (LAST) (FIR		essionai i		DDLE)		2. Date o	of Dirth			3. Gender
Residence address (number, street)				City	City				State	ZIP code (nine-digit)
5. Mailing address (number, street)				City	City				State	ZIP code (nine-digit)
6. Social security number (mandatory)		(attach	er's license or state- a current and legib	e copy	/)					
Professional license/certificate/permit number (current and legible copy)	attach	Licen	se effective date / /	Lic	ens	se expiration List specialty(ies) (if applicable date				ty(ies) (if applicable)
Business address at which services are provide	ed (suite	and/or ro	oom number, street)	number, street). City				State	1	ZIP code (nine- digit)
Name of entity at which services are being pro	ovided.	1	1. Provider number	(NPI) c	of th	e clinic a	t which	servic	es are	being provided :
12. If the applicant is a substance use disorder med (attached additional sheets if necessary).										
If the applicant is a licensed substance use disc proceed to Number 13.	order trea	atment pi	rofessional, or subs	tance	use	disorde	r nonph	ysıcıa	n medi	cal practitioner, please
Clinic Name		Business Address						PROVIDER NUMBER (NPI)		
13. Proof of Professional Liability Insurance –applic	ant/provi	der must	attach a current and	egible	cop	y of their	certifica	te of (r	nalpract	tice) insurance
Name of insurance company			Insurance ager	t's nan	ne (first, midd	lle, last,	Jr., Sr.	, etc.	

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Date policy issued (mm/dd/yyyy)

Telephone number Expiration date of policy (mm/dd/yyyy) II. DISCLOSURE INFORMATION Respond to the following questions Within ten years of the date of this statement, have you, the applicant/provider, been convicted of any felony or □Yes \square No misdemeanor involving fraud or abuse in any government program? If yes, provide the date of the conviction (mm/dd/yyyy): _____ Within ten years of the date of this statement, have you, the applicant/provider, been found liable for fraud abuse involving a government program in any civil proceeding? □Yes □No If yes, provide the date of the final judgment (mm/dd/yyyy): ___ 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 □Yes \square No program or in any other State's Medicaid program? If yes, provide the following information: NPI AND/OR NAME(S) **STATE** (LEGAL AND DBA) PROVIDER NUMBER(S) 5. Have you, the applicant/provider, ever been suspended from a Medicare, Medi-Cal, or another State's □Yes □No Medicaid program? If yes, attach verification of reinstatement and provide the following information: NPI AND/OR CHECK PROVIDER NUMBER(S) EFFECTIVE DATE(S) OF DATE(S) OF REINSTATEMENT(S). APPLICABLE **PROGRAM** SUSPENSION AS APPLICABLE ☐ Medi-Cal ☐ Medicaid ☐ Medicare ☐ Medi-Cal ☐ Medicaid □ Medicare 6. Has the individual license, certificate or other approval to provide health care services of the applicant/provider □Yes □No ever been suspended or revoked? 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: **EFFECTIVE DATE(S) OF** WHERE (STATE) ACTION(S) WAS TAKEN **ACTION(S) TAKEN** 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? 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: **EFFECTIVE DATE(S) OF** LICENSING AUTHORITY'S ACTION(S) WHERE (STATE) ACTION(S) WAS TAKEN **ACTION(S) TAKEN** 8. Has the license, certificate or other approval to provide health care services of the applicant/provider *ever* been \quad \text{Yes} disciplined by any licensing authority? If yes, attach a copy of the written confirmation from the licensing authority decision(s) including any terms and conditions for each decision

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EFFECTIVE DATE(S) OF

and provide the following information:

III. PROVIDER AGREEMENT I understand that this type of enrollment does not allow the Medi-Cal program to reimburse the applicant/provider declare under penalty of perjury under the laws of the State of California that the foregoing informaticate that is strue, accurate and complete to the best of my knowledge and belief and that I am authorized to Title 22, California Code of Regulations, Sections 51000.30(a)(2)(B). I understand that the failure to disclose the required information, or termination of enrollment status and program, which shall include deactivation of all provider numbers (NPI's) used in the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Provider Enrollment Division. I hereby further declare that I will abide by all Medi-Cal laws and regulations and Medi-Cal program policic requirements for record keeping and the disclosure of information. I understand that compliance with all Microdification participation as a substance use disorder medical director, licensed substance use disorder medical director, licensed substance use disorder medical director, or participation as a substance use disorder medical director, licensed substance use disorder to use disorder nonphysician medical practitioner with the Medi-Cal program. I also agree that DHCS, the County, and/or Attorney General (AG) may make unannounced visits to a Applicant's Provider's business locations, before, during and after enrollment, for the purpose of determining enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to an ender englect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as the Medi-Cal program and/or as the Medi-Cal program and the Medi-Cal program in the Medi-Cal program to provided. I certify that I am an individual practitioner who is applying for	SING AUTHORITY'S ACTION(S)	LICENSING	N(S) TAKEN	ACTION	WAS TAKEN	HERE (STATE) ACTION(S) W
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understand that the failure to disclose the required information, or the disclosure of false information, shall he denial of the application for enrollment or shall be grounds for termination of enrollment status and program, which shall include deactivation of all provider numbers (NPI's) used in the Medi-Cal program. understand that I must report changes in the foregoing information within 35 days to the Department of Provider Enrollment Division. hereby further declare that I will abide by all Medi-Cal laws and regulations and Medi-Cal program policie requirements for record keeping and the disclosure of information. I understand that compliance with all Micondition for participation as a substance use disorder medical director, licensed substance use disorder medical director, licensed substance use disorder of the medi-Cal program. also agree that DHCS, the County, and/or Attorney General (AG) may make unannounced visits to A Applicant's/Provider's business locations, before, during and after enrollment, for the purpose of determining and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as ne the Medi-Cal program and/or fulfillment of the AG's powers and duties under Government Code Sectionspection as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by Diagent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider for program. It certify that I am an individual practitioner who is applying for the sole purpose of enrolling medical director, licensed substance use disorder treatment professional, or substance use disorder treatment professional, or substance use disorder treatment professional, or substance use disorder director, licensed substance use disorder treatment professional, or substance use disorder treatment professional. Printed legal name of applicant/provider (Last) (First) (Middle Email address Telephone Number Cole at the program and the program and the pro			dge and belief and that	the best of my knowledg	nd complete to the	hments is true, accurate and d
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E-mail address Applicant's/Provider's Original Signature (in ink) (City) (State) Executed at:	sorder nonphysician medical	ance use disord	professional, or sub	disorder treatment p	ubstance use	ical director, licensed sub titioner. I understand tha
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PRIVACY STATEMENT (Civil Code Section 1798 et seq.)



All information requested on the application, the disclosure statement, and the provider agreement is mandatory. 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 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 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. 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 DHCS, contact the Provider Enrollment Division at (916) 323-1945.

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