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 sole purpose of enrollment of the substance use disorder medical director, licensed substance use disorder treatment professional, or substance use disorder nonphysician medical practitioner. This type of enrollment does not 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.
   6. "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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11. "Provider number (NPI) of substance use disorder clinic site at which services are being provided" – enter the NPI for the substance use disorder clinic site that the applicant/provider provides services to.
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.

PROPOSED

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

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

FOR STATE USE ONLY

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.

Provider Number (NPI):	**Provider Type:**	**Date** / /

ENROLLMENT ACTION REQUESTED

☐ New Substance Use Disorder Medical Director
☐ New Substance Use Disorder Nonphysician Medical Practitioner
☐ New Licensed Substance Use Disorder Treatment Professional

☐ Continued Enrollment (Do not check this box unless you have been requested by DHCS to apply for continued enrollment in the Medi-Cal program.)

I. IDENTIFYING INFORMATION

1. Legal name of applicant/provider (as it appears on professional license) *(LAST)* *(FIRST)* *(MIDDLE)*	2. Date of birth / /	3. Gender

4. Residence address (number, street)	City	State	ZIP code (nine-digit)
5. Mailing address (number, street)	City	State	ZIP code (nine-digit)

6. Social security number (mandatory)	7. Driver's license or state-issued identification card number and state of issuance (attach a current and legible copy)		
8. Professional license/certificate/permit number (attach current and legible copy)	License effective date / /	License expiration date	List specialty(ies) (if applicable)

9. Business address at which services are provided (suite and/or room number, street).	City	State	ZIP code (nine-digit)

10. Name of entity at which services are being provided.	11. Provider number (NPI) of the clinic at which services are being provided :

12. If the applicant is a substance use disorder medical director, please list all substance use disorder clinics currently supervised by the applicant/provider (attached additional sheets if necessary).

If the applicant is a licensed substance use disorder treatment professional, or substance use disorder nonphysician medical practitioner, please proceed to Number 13.

Clinic Name	Business Address	PROVIDER NUMBER (NPI)

13. Proof of Professional Liability Insurance –applicant/provider must attach a current and legible copy of their certificate of (malpractice) insurance

Name of insurance company	Insurance agent's name (first, middle, last, Jr., Sr., etc.

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Telephone number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)

II. 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 abuse involving a government program in any civil proceeding? ☐Yes ☐No

   If yes, provide the date of the 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 any other State's Medicaid program? ☐Yes ☐No

If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	NPI AND/OR PROVIDER NUMBER(S)

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

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

CHECK APPLICABLE PROGRAM	NPI AND/OR 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 services 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 (STATE) ACTION(S) WAS TAKEN	**ACTION(S) 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 (STATE) ACTION(S) WAS TAKEN	**ACTION(S) TAKEN**	**EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)**

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

If yes, attach a copy of the written confirmation from the licensing authority decision(s) including any terms and conditions for each decision and provide the following information:

		EFFECTIVE DATE(S) OF

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WHERE (STATE) ACTION(S) WAS TAKEN	ACTION(S) TAKEN	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 arrangement(s) 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
		/ /	/ /
		/ /	/ /

III. PROVIDER AGREEMENT

I understand that this type of enrollment does not allow the Medi-Cal program to reimburse the applicant/provider for services provided.

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments is true, accurate and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to Title 22, California Code of Regulations, Sections 51000.30(a)(2)(B).

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 (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 Health Care Services ("DHCS"), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and Medi-Cal program policies and procedures, 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 substance use disorder medical director, licensed substance use disorder treatment provider, or substance 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 Applicant/Provider, at any of the Applicant's/Provider's business locations, before, during and 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 fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS, the County, or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

I certify that I am an individual practitioner who is applying for the sole purpose of enrolling as a substance use disorder medical director, licensed substance use disorder treatment professional, or substance use disorder nonphysician medical practitioner. I understand that this enrollment type does not allow the Medi-Cal program to reimburse me for services provided.

Printed legal name of applicant/provider (Last) (First) (Middle)

E-mail address	Telephone Number

Applicant's/Provider's Original Signature (in ink)

(City) (State) (Date)

Executed at: _____, _____ on _____

Contact Person's Information: ☐ Check here if you are the same person identified in Item 1 of this section

Contact person's name

Title/Position	E-mail address	Telephone number

PRIVACY STATEMENT (Civil Code Section 1798 et seq.)

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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.