



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



JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Provider:

Thank you for your recent request for the *Medi-Cal Supplemental Changes* form, *DHCS 6209 (rev. 12/14)*. Please complete the enclosed form and return it to:

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

Please read all the instructions included in the *Medi-Cal Supplemental Changes* form carefully and complete each item requested. Incomplete forms 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 (NPES) 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 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. 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.

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 below or via email at PEDCorr@dhcs.ca.gov.

Please visit the Medi-Cal website at www.medi-cal.ca.gov for information on submitting claims electronically. A submitter number is not transferable. A new submitter number must be obtained each time a new Medi-Cal provider number is issued by DHCS. If you have any questions about obtaining an electronic billing submitter number, call the Telephone Service Center at (800) 541-5555 and select the option for Computer Media Claims.

Provider Enrollment Division

Enclosures

(12/14)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL SUPPLEMENTAL CHANGES

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.

This form is a means to inform the Department of Health Care Services (DHCS) of any changes to previously submitted provider information and documentation. Applicants or providers may be subject to an on-site inspection prior to enrollment.

Omission of any required information or documentation on this form, including not signing the form may result in your records with Medi-Cal not being updated as requested.

You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for any National Provider Identifier (NPI) added with this form. Any change in an NPI for an enrolled location requires that the confirmation reflect the enrolled location's address. 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.

Enter the legal provider name as listed with the Internal Revenue Service (IRS).

Enter your provider number (NPI or Denti-Cal provider number as applicable) in the space provided.

Enter the date you are completing the application.

Provider type: Enter your provider type in one of the boxes provided.

Action requested: Check the applicable action you would like made to the provider master file.

“Deactivate provider number” will deactivate all enrolled locations using the provider number submitted. To deactivate an enrolled provider type or location, please attach a cover letter specifying the deactivation request.

Please complete only those boxes necessary to provide the information you are adding, changing, or deleting or to complete the action requested. Be sure to complete boxes 40-45; complete box 46, if applicable.

GENERAL INFORMATION

1. “Business name” – enter the name of the applicant or provider if different than legal name. If this is a fictitious business name, provide a copy of the Fictitious Business Name Statement or Fictitious Name Permit number and effective date.
2. “Business telephone number” – enter 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.
3. “Pay-to address” – enter the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the number, street name, room, suite number or letter, P.O. box number, city, state, and nine-digit ZIP code. **An applicant or provider may assign only one pay-to-address per NPI. Please note, substance use disorder clinics may not use the DHCS 6209 to update their “Pay-to Address.”**
4. “Mailing address” – enter the address where the applicant or provider wishes to receive general Medi-Cal correspondence including Provider Bulletins and Provider Manual updates.
5. a. Insert the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA Certificate.
b. Insert the State Laboratory License/Registration number. Attach a legible copy to the application.
6. Insert any additional NPI for the entity indicated in number 1. Attach CMS/NPPES confirmation for each. Providers not eligible to receive an NPI (atypical providers) must submit a Medicare billing number.
7. Insert the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.

8. Insert any local business license, permit, or certificate numbers for any city and/or county where you conduct your business activities and attach legible copies to the application.
9.
 - a. Insert the specialty code(s) to be added or deleted, if applicable (see Physician/Nonphysician Practitioner Specialty Codes on page 14.
 - b. Insert the taxonomy code(s) to be added or deleted from your NPI. These taxonomy codes must already be registered with NPPES prior to submission to Medi-Cal. Attach additional sheets if necessary.

CHANGE OF OWNERSHIP OR CONTROL INTERESTS

10. For a change of ownership or control interests of less than 50 percent, list the new ownership information in this space and submit a new Medi-Cal Disclosure Statement (DHCS 6207) for all new ownership interests. If there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Section 51000.15, since the information provided in the last complete application that was approved for enrollment, a complete application package must be submitted pursuant to Title 22, California Code of Regulations, Section 51000.30(b).

CHANGE IN HOURS OF OPERATION

11. "Hours of operation"—enter the business days and hours the provider is available for service to Medi-Cal beneficiaries.

FOR DURABLE MEDICAL EQUIPMENT AND PHARMACY PROVIDERS ONLY

12. Check the appropriate box indicating whether the applicant provides "custom rehabilitation equipment" and "custom rehabilitation technology services" to Medi-Cal beneficiaries. If you answer yes, check the appropriate box whether the applicant has on staff, either as an employee or independent contractor, or the applicant has a contractual relationship with, a "qualified rehabilitation professional" who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment.

"Custom rehabilitation equipment" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.

"Custom rehabilitation technology services" means the application of enabling technology systems designed and assembled to meet the needs of a specific person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate, the documentation of medical necessity, the selection, fit, customization, maintenance, assembly, repair replacement, pickup and delivery, and testing of equipment and parts, and the training of an assistant caregiver and of a patient who will use the equipment or individuals who will assist the patient in using the equipment.

"Qualified rehabilitation professional" means an individual to whom any one of the following applies:

- (a) The individual is a physical therapist licensed pursuant to the Business and Professions Code, occupational therapist licensed pursuant to the Business and Professions Code, or other qualified health care professional recognized by the Department.
- (b) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers, or other credentialing organization recognized by the Department.
- (c) The individual has successfully passed one of the following credentialing examinations administered by the Rehabilitation Engineering and Assistive Technology Society of North America:
 - (i) The Assistive Technology Supplier examination.
 - (ii) The Assistive Technology Practitioner examination.
 - (iii) The Rehabilitation Engineering Technologist examination.

13. Enter the change in the business activity you are adding and the licensing information, if applicable. Attach legible copies of any licenses, certificates, or permits required. If you have questions regarding the Bureau of Home Furnishings license, please call the Bureau at (916) 574-0280; or for the Home Medical Device Retailers license call the Food and Drug Branch at (916) 650-6518. To calculate percentages of business activities, refer to the Medi-Cal Durable Medical

Equipment Provider Application (DHCS 6201). If deleting incontinence medical supplies, check the box.

14. Check the appropriate boxes and complete all requested information.

FOR TRANSPORTATION PROVIDERS ONLY

15. "Geographic Area(s) Served" - enter those areas in which the provider will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit with the application. If the city/county does not require a license/permit, you must attach a letter from that city/county with the application which states the city/county does not require a license/permit. It is the applicant's or provider's responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.

16. Provide the following information and attach legible copies if

applicable: Ambulance:

- Certificate number issued by the California Highway Patrol (CHP) - attach a legible copy of the certificate to the application
- Issue date
- Vehicle Identification Number (VIN) of each vehicle that will be used to transport beneficiaries
- Make and model of vehicle
- Year of vehicle
- License plate number of vehicle
- EMS verification

Driver:

- Full legal name of driver
- Driver's license number
- Driver's license year of expiration
- Ambulance Driver Certificate number
- DMV DL-51 effective and expiration dates (for driver's only)

17. Provide the following information and attach legible copies if

applicable: Aircraft:

- Certificate number issued by the Federal Aviation Administration (FAA) - attach a legible copy of the certificate to the application
- Name and address where the aircraft is hangared - This statement must also be on your company letterhead and be attached to the application
- EMS verification

Pilot:

- Full legal name of pilot
- Pilot's driver's license number or state issued identification card
- Pilot's license number with year of expiration
- Copy of FAA pilot's license for each pilot
- Copy of pilots driver's license or state issued identification card

18. Provide the following information and attach legible copies if applicable:

Vehicle Information (litter and/or wheelchair van):

- VIN of each vehicle that will be used to transport beneficiaries
- Photographs of vehicle (i.e., view of inside, back exit door, side exit door, and view of business name)
- Make and model of vehicle
- Year of vehicle
- License plate number of vehicle
- DMV vehicle registration
- Proof of vehicle insurance
- Brake and lamp certificate
- Special vehicle permit (if applicable)

Driver Information

- Full legal name of driver
- Driver's license number
- DMV driving record printout for each driver
- Certificates for first aid and CPR for each driver
- Standard pre-employment drug and alcohol tests lab results for each driver
- California driver's license for each driver
- Special driver's permit (if applicable)
- DMV DL-51 form signed by a physician for each driver

FOR PHARMACIES ONLY

19. Insert the last, first, and middle name of the pharmacist-in-charge at the business location.
20. Provide the social security number of the pharmacist-in-charge.
21. Insert the license number of the pharmacist-in-charge. Attach a legible copy of license renewal, if applicable.
22. Provide the driver's license or state-issued identification number and state of issuance of the pharmacist-in-charge. Attach a legible copy of the driver's license or state-issued identification card to this application.
23. - 28. Answer all questions as they pertain to the pharmacist-in-charge. If any answers are checked yes, list all details to include license number, dates, licensing agency, Medi-Cal provider information and numbers, etc., in number 29.
29. Provide all details to any yes answers for numbers 23 - 28.

PROVIDERS OF SUBSTANCE USE DISORDER TREATMENT SERVICES ONLY

New Substance Use Disorder Medical Director or Physician Making Medical Necessity Determinations

30. Insert the last, first, and middle name of the substance use disorder medical director, or physician determining medical necessity at the business location.
31. Provide the provider number (NPI) of the substance use disorder medical director or physician determining medical necessity. Attach CMS/NPPES confirmation to this application.
32. Provide the medical license number of the substance use disorder medical director or physician determining medical necessity. Attach a legible copy to this application.

Substance Use Disorder Treatment Professional/Licensed Substance Use Disorder Treatment Professional

33. Provide the following information and attach copies if applicable:
 - Full legal name
 - Provider Number (NPI) if applicable
 - Provider Type (see CCR, Title 22, Section 51051)
 - License, Certification, or Registration Number (attach a legible copy of license/certification/registration)
 - Check whether the individual is being deleted or added

Service Modality(ies)

34. Enter all services to be provided by the DMC clinic, including existing services and additional services or program types being requested by this application. Note – DMC residential services require a residential alcoholism or drug use recovery treatment facility license issued by DHCS. A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP services. Facility licensing and NTP information and applications are available online at www.dhcs.ca.gov/provgovpart/Pages/SUD-ProvPartners.aspx.

NATIONAL PROVIDER IDENTIFIER (NPI) SUBPARTING

35. See instructions for subparting information.
36. Check the appropriate box.
37. Provide all details regarding the addition(s) or change(s) if you answered yes to the previous question.

38. Check the appropriate box.
39. Provide all details regarding the addition(s) or change(s) if you answered yes to the previous question. (See CCR, Title 22, Sections 51000.30 and 51000.40).

INFORMATION ABOUT PROVIDER

40. Printed name of provider signing this form - enter the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to DHCS for enrollment or continued enrollment as a provider in the Medi-Cal program.
41. Enter the date of birth of the individual named in number 40.
42. Check the gender of the individual named in number 40.
43. Provide the driver's license or state-issued identification number and state of issuance of the individual listed in number 40. 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.
44. Provide the social security number of the individual named in number 40. Provision of the social security number is required (see Privacy Statement page 13).
45. An original signature of the individual listed in number 40 is required. Also provide the title of the person signing the application who is the sole proprietor, partner, corporate officer, or by an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. Include the city, state, and the date where and when the application was signed. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this form.**
46. 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 Person's Information

47. To assist in the timely processing of the application package, enter the name, gender, title/position, 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 the application package being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

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

- National Provider Identifier (NPI) verification (CMS/NPPES confirmation)
- Fictitious Business Name Statement or Fictitious Name Permit
- TIN verification
- CLIA Certificate
- State Laboratory License/Registration
- Seller's Permit
- Professional license, permit, or certificate
- Business license, permit, or certificate
- Licenses associated with business activities
- Bureau of Home Furnishings License
- Furniture and Bedding License
- Furniture License
- Bedding License
- Home Medical Device Retailer License
- Home Medical Device Retailer Exemptee License
- Other licenses, certificates, permits, etc.
- Pharmacist-in-Charge License
- Pharmacist-in-Charge driver's license or identification card
- Medical Director License
- Certificates for first aid and CPR for each new driver
- Driver's license for each new driver
- DMV DL-51 form signed by a physician for each new driver
- Standard pre-employment drug and alcohol tests lab results for each new driver
- DMV driving history printout for each new driver
- Driver's license or identification card of person signing application
 - Proof of insurance
 - Brake and Lamp Certificate
- FAA certificate
- FAA pilot's license for each new pilot
- Signed Medi-Cal Disclosure Statement (DHCS 6207)
- Medicare enrollment verification
- Residential License issued by the DHCS (if applicable)
- Narcotic Treatment Program License issued by the DHCS (if applicable)
- Substance use disorder medical director, or physician determining medical necessity, professional license
- The license, certification, and/or registration of the substance use disorder treatment professional or licensed substance use disorder treatment professional providing counseling services

MEDI-CAL SUPPLEMENTAL CHANGES



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 997412
 - Sacramento, CA 95899-7412
 - (916) 323-1945
- For Denti-Cal return completed forms to:
 - Medi-Cal Dental Program (Denti-Cal)
 - Provider Enrollment
 - P.O. Box 15609
 - Sacramento, CA 95852-0609
 - (800) 423-0507

| |
|---|
| <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> FOR STATE USE ONLY </div> |
|---|

• **This is not the correct form for reporting a change in business address.**

| | | |
|--|--|------|
| Legal provider name (as listed with the IRS) | Provider Number (NPI or Denti-Cal provider number as applicable) | Date |
|--|--|------|

PROVIDER TYPE (check one)

| | |
|--|---|
| <input type="checkbox"/> Dentist <input type="checkbox"/> DME <input type="checkbox"/> Laboratory <input type="checkbox"/> Orthotic and prosthetic <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Substance use disorder clinic <input type="checkbox"/> Physician <input type="checkbox"/> Provider group <input type="checkbox"/> Registered Dental Hygienist Alternative Practice <input type="checkbox"/> Transportation <input type="checkbox"/> Other provider type (please describe) _____ |
|--|---|

ACTION REQUESTED (check all that apply)

- Add:**
- Business Activity
 - Clinical Laboratory Improvement Amendment (CLIA)
 - Doing-Business-As (DBA) name
 - Licenses, permits, certificates, etc.
 - Medical transportation vehicle, driver or pilot
 - Seller's Permit
 - Medicare/Other NPI
 - Specialty Code
 - Taxonomy Code
 - Service Modality(ies) (substance use disorder clinics only)

- Delete:**
- Clinical Laboratory Improvement Amendment (CLIA)
 - Medical transportation vehicle, driver, or pilot
 - Specialty Code
 - Service Modality(ies) (substance use disorder clinic only)

- Change:**
- NPI assigned to one or more locations--**see page 12**

Change (continued):

- Address and/or phone (pay-to or mailing only)
List any provider numbers the change is associated with: _____
 - Medical transportation vehicle, driver, pilot or geographic area served
 - Persons with ownership or control interest less than 50 percent
 - Pharmacist-in-charge
 - Managing employee
 - Hours of operation
 - Business activities
 - Other information previously submitted in an application package
 - Substance use disorder medical director or physician making medical necessity determinations (substance use disorder clinics only)
 - Substance use disorder treatment professional or licensed substance use disorder treatment professional providing counseling services (substance use disorder clinics only)
- Miscellaneous:**
- PIN (Provider Identification Number)
- Issuance (new PIN) Note: Provider of substance use disorder treatment services may not use this form for PIN reissuance.
 - Confirmation (existing PIN)
 - Deactivate provider number _____
 - Deactivate provider type/location (attach letter specifying change)

Complete only the boxes specific to the action requested. Complete boxes 40 - 45. Complete box 46, if applicable.

GENERAL INFORMATION

| | | | |
|--|---|------------------------------|---------------------|
| 1. Business name, if different | | 2. Business telephone number | |
| Is this a fictitious business name? | | () | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, list the Fictitious Business Name Statement/Permit number | Effective date | |
| (Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit, if applicable.) | | | |
| 3. Pay-to address (number, street name, room, suite, or P.O. Box number) | City | State | Nine-digit ZIP code |

| | | | |
|--|--|---|---------------------|
| 4. Mailing address (number, street, P.O. Box number) | City | State | Nine-digit ZIP code |
| 5.a. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy) | 5.b. State Laboratory License/Registration number (attach a legible copy) | 6. Medicare/Other NPI/Medicare Billing Number (see instructions) | |
| 7. Seller's Permit number (attach a legible copy) | 8. Any local business license, permit or certificate numbers (attach a legible copy) | 9.a. Specialty code(s), if applicable Add: _____ Delete: _____ | |

9.b. Taxonomy Codes (attach additional sheets if necessary)

Add: _____

Delete: _____

10. Change of Ownership or Control Interests—Less than 50% cumulative changes since last complete application approved for this provider number.

Type of entity (check one)

- Sole proprietor
 Partnership (Attach legible copy of agreement)
 Corporation
 Nonprofit
 Limited liability company
 Government
 Other (describe)

Are you adding owners, managing employees, or change in interest? If so, please provide the following information:

| Name | Title | Ownership percentage |
|------|-------|----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Are you deleting owners? If so, please provide the following information:

| Name | Title | Ownership percentage |
|------|-------|----------------------|
| | | |
| | | |
| | | |
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| | | |

11. CHANGE IN HOURS OF OPERATION

The business days and hours of operation are:

Days: _____ Hours: _____

FOR DURABLE MEDICAL EQUIPMENT AND PHARMACY PROVIDERS ONLY

12. Do you provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? Yes No

If yes, do you have on staff, either as an employee or independent contractor, or do you have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment? Yes No

13. Change in Business Activities

Add (please describe activities and percentages to equal 100%. Attach additional page.) _____

If you are adding a business activity which requires any type of license, certificate, permit, etc., please list the information here and attach a legible copy of the license to this application: _____

Bureau of Home Furnishings license (see instructions):

Furniture and Bedding or Furniture Retailer License number (attach a legible copy): _____ Registry number: _____

(If you are a DME provider and are renting beds, your license must bear a Registry number.)

Issuance date: _____ Expiration date: _____

Home Medical Device Retailer License (attach a legible copy): _____

Issuance date: _____ Expiration date: _____

Home Medical Device Retailer Exemptee License (attach a legible copy): _____

Issuance date: _____ Expiration date: _____

Other license, certificate, permit, etc. (attach a legible copy): _____

Delete incontinence medical supplies

14. Do you sell, rent, or lease durable medical equipment, incontinence medical supplies and/or supply items? Yes No

If yes, do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operation? Yes No

If no, please explain

Are your equipment and/or supplies:

- A. In stock on the premises, or
- B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation: Days: _____ Hours: _____

If B is checked, provide the following information for the warehouse:

| | | | |
|--------------------------|------|-------|---------------------|
| Address (number, street) | City | State | Nine-digit ZIP code |
|--------------------------|------|-------|---------------------|

Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

| | | | |
|--------------------------|-------------------------|-------|---------------------|
| Name | Telephone number () | | |
| Address (number, street) | City | State | Nine-digit ZIP code |

FOR TRANSPORTATION PROVIDERS ONLY

15. Geographic area(s) served (list city/county—attach copy of permit/license)

16. Ambulance and Driver Information—see instructions (attach a separate sheet, if necessary)

Ambulance Information

| CHP Certificate Number | Issue Date | Vehicle Identification Number(s) | Make and Model of Vehicle | Year | License Plate Number | Add (✓) | Delete (✓) |
|------------------------|------------|----------------------------------|---------------------------|------|----------------------|---------|------------|
| | | | | | | | |
| | | | | | | | |

Ensure legible copies of the following documents for each ambulance are attached to the application:

- CHP 301 certificate
- EMS Certificate, local
- CHP 360A Ambulance license

Driver Information (attach a legible copy(ies) of driver's license(s) and DMV DL-51(s))

| Driver's Name(s) | Driver's License Number | Year of Expiration | Ambulance Driver Certificate Number | DMV DL-51 (Driver's Only) | | Add (✓) | Delete (✓) |
|------------------|-------------------------|--------------------|-------------------------------------|---------------------------|-----------------|---------|------------|
| | | | | Effective Date | Expiration Date | | |
| | | | | | | | |
| | | | | | | | |

26. Has the PIC previously participated in the Medi-Cal program?
27. Has the PIC ever participated in another State's Medicaid program?
28. Has the PIC ever been suspended from a Medicare or Medicaid program?
29. Details for questions 23–28 (see instructions):

PROVIDERS OF SUBSTANCE USE DISORDER TREATMENT SERVICES ONLY

NEW SUBSTANCE USE DISORDER MEDICAL DIRECTOR, OR OTHER PHYSICIAN MAKING MEDICAL NECESSITY DETERMINATIONS*

30. Printed Legal Name (last) (first) (middle)

31. Provider Number (NPI)

32. Medical License Number (attach a legible copy)

**If the substance use disorder medical director or physician making medical necessity determinations is not currently enrolled as such, a Drug Medi-Cal Substance Use Disorder Medical Director/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Non-physician Medical Practitioner Application/Agreement/Disclosure Statement" DHCS 6010, must be submitted for the individual in number 30.*

SUBSTANCE USE DISORDER TREATMENT PROFESSIONAL/LICENSED SUBSTANCE USE DISORDER TREATMENT PROFESSIONAL PROVIDING COUNSELING SERVICES (attach additional sheets if necessary)

33.

| Legal Name | Provider Number (NPI, if applicable) | Provider Type | License, Certification, or Registration Number (attach legible copy of license/certification/registration) | Delete (✓) | Add (✓) |
|------------|--------------------------------------|---------------|--|------------|---------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

SERVICE MODALITY(IES)

34. Identify the service modality(ies) and treatment component(s) (non-perinatal or perinatal) requested for the site. Include service modality(ies) and treatment component(s) that the provider wishes to continue as well as those to be added.

Applicants for residential services must first obtain a residential license issued by the DHCS prior to application submission for DMC residential services. A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP services.

| Type of Services | Current and/or requested Treatment Component | |
|---|--|------------------------------------|
| Narcotic Treatment Program (NTP) (attach copy of license) License #: | <input type="checkbox"/> Non-perinatal | <input type="checkbox"/> Perinatal |
| Intensive Outpatient Treatment (IOT) | <input type="checkbox"/> Non-perinatal | <input type="checkbox"/> Perinatal |
| Outpatient Drug Free (ODF) | <input type="checkbox"/> Non-perinatal | <input type="checkbox"/> Perinatal |
| Residential License #: (attach copy of license) | <input type="checkbox"/> Non-perinatal | <input type="checkbox"/> Perinatal |
| Naltrexone | <input type="checkbox"/> Non-perinatal | <input type="checkbox"/> Perinatal |

NATIONAL PROVIDER IDENTIFIER (NPI) SUBPARTING

General Subparting Instructions

The table below is intended for applicants and providers who have subparted and wish to change an NPI assigned to one or more Medi-Cal enrolled locations. An applicant or provider must determine whether or not to subpart based on their business practices, billing practices and federal requirements including the NPI Final Rule.

A subpart is a component of a health care organizational provider, such as a provider group, that is not a person. A subpart furnishes health care and might:

- Conduct standard transactions
- Be required by Federal regulations to have a Federal billing number (e.g., Medicare billing number)
- Be certified/licensed separately from the covered organization
- Have a location different from the covered organization
- Be a member of a chain
- Be a DMEPOS provider

If you are an individual sole proprietor (unincorporated) health care provider such as a physician, dentist, nurse, chiropractor, etc., you do not qualify to subpart. When you receive your NPI you will be identified with an Entity Type Code 1 (Health care providers who are individual human beings, including sole proprietors).

If you are an organization, you may subpart. When you receive your NPI you will be identified with an Entity Type Code 2 (Health care provider who is other than an individual human being). Examples of organizations are hospitals; individuals who have incorporated; home health agencies; clinics; nursing homes; residential treatment centers; laboratories; emergency and nonemergency medical transportation companies; group practices; suppliers of durable medical equipment; prosthetics and orthotics providers; and pharmacies.

For additional information, please see the Centers for Medicare and Medicaid Services website at: <https://www.cms.hhs.gov/NationalProviderStand/> for comprehensive information regarding subparting and general NPI implementation.

35. Subpart Designation Table

“Enrolled business location”—You must be currently enrolled at this location.

“NPI currently on file”—Indicate the NPI assigned to the enrolled business location at the time this form is submitted.

“New NPI being assigned to the location”—Indicate the new NPI you wish to have assigned to the enrolled business location listed.

| Enrolled Business Location | | | NPI currently on file | New NPI being assigned to the location |
|----------------------------|------|----------|-----------------------|--|
| Number and street | City | Zip Code | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

Attach additional sheets if necessary. Remember to attach verification of any new NPIs assigned. **Any change in an NPI for an enrolled location requires that the confirmation reflect the enrolled location’s address.**

OTHER INFORMATION

36. Are you reporting any addition(s) or changes(s) in information to a pending application? Yes No

37. If you answer yes to the prior question, please explain:

38. Are you reporting any addition(s) or change(s) in information submitted in a prior application package other than information covered elsewhere in this form that does not require the submission of a new application package? Yes No

39. If you answer yes to the prior question, please explain:

INFORMATION ABOUT PROVIDER

| | | | | |
|--|--|---|-------------------|---|
| 40. Printed name (last) (first) (middle) | | | 41. Date of birth | 42. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 43. Driver's license or state-issued identification number and state of issuance (attach a legible copy) | | 44. Social security number (Required, see privacy statement below) _____ - _____ - _____ | | |

45. 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 pursuant to Title 22, CCR Section 51000.30(a)(2)(B).

| | |
|-----------------------|-------|
| Signature of provider | Title |
|-----------------------|-------|

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

46. Notary Public—Please see instructions under number 46 for who must have their form signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

47. Contact Person's Information

Check here if you are the same person identified in number 40. If you checked the box, provide only the email address and telephone number below.

| | | | |
|---|----------------|------------------|--|
| Contact Person's Name (last) (first) (middle) (gender) | | | |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | | | |
| 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. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 - 14043.75, the California Code of Regulations, Title 22, Sections 51000 - 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and 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. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California 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, or as required or permitted by law. 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 contact Denti-Cal at (800) 423-0507.

PHYSICIAN/NONPHYSICIAN MEDICAL PRACTITIONER SPECIALTY CODES

| Specialty | Code | Specialty | Code |
|--|-------------|--|-------------|
| Allergy | 03 | Pediatrics | 40 |
| Anesthesiology | 05 | Pharmacology-Clinical | 91 |
| Aviation (MD Only) | 11 | Physical Medicine & Rehabilitation | 25 |
| Cardiovascular Disease (MD Only) | 06 | Plastic Surgery | 24 |
| Clinics-Mixed Specialty | 70 | Proctology (Colon & Rectal) | 28 |
| Dermatology | 07 | Psychiatry | 36 |
| Emergency Medicine (Urgent Care) | 66 | Psychiatry-Child | 26 |
| Endocrinology | 67 | Public Health | 44 |
| Family Practice-House Calls | 08 | Pulmonary Diseases (MD only) | 29 |
| Gastroenterology (MD Only) | 10 | Radiology | 30 |
| General Practice (General Medicine) | 01 | Rheumatology | 83 |
| General Surgery | 02 | Surgery-Head & Neck | 84 |
| Geriatrics | 38 | Surgery-Traumatic | 89 |
| Hand Surgery | 46 | Thoracic Surgery | 33 |
| Hematology | 68 | Unknown | 99 |
| Infectious Disease | 77 | Urology, Urological Surgery | 34 |
| Internal Medicine | 41 | | |
| Miscellaneous | 47 | Specific to Osteopathic Physicians Only | |
| Neoplastic Diseases | 78 | Gynecology | 09 |
| Nephrology (Renal-Kidney) | 45 | Manipulative Therapy | 12 |
| Neurological Surgery | 14 | Ophthalmology, Otolaryngology, Rhinology | 17 |
| Neurology (MD Only) | 13 | Pathologic Anatomy, Clinical Pathology | 21 |
| Neurology-Child | 79 | Peripheral Vascular Disease or Surgery | 23 |
| Nuclear Medicine | 42 | Psychiatry Neurology | 27 |
| Obstetrics | 15 | Peripheral Vascular Disease or Surgery | 23 |
| Obstetrics-Gynecology (MD Only) Neonatal | 16 | Radiation Therapy | 32 |
| Oncology | 78 | Roentgenology, Radiology | 31 |
| Ophthalmology | 18 | | |
| Orthopedic Surgery | 20 | Nonphysician Medical Practitioner | |
| Otology, Laryngology, Rhinology (ENT) | 04 | Nurse Practitioner | 2 |
| Pathology (MD Only) | 22 | Physician Assistant | 3 |
| Pathology-Forensic | 90 | Nurse Midwife | 4 |
| Pediatric Allergy | 43 | | |
| Pediatric Cardiology (MD Only) | 35 | | |