



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

April 28, 2016

Dear Medi-Cal Provider:

**NOTIFICATION OF REVALIDATION FOR CONTINUED PARTICIPATION IN THE  
MEDI-CAL PROGRAM---RESPONSE REQUIRED WITHIN 35 DAYS OF THE DATE OF  
THIS NOTICE**

This letter provides written notice that pursuant to the California Code of Regulations, (CCR), Title 22, Section 51000.55, the Department of Health Care Services (DHCS) is revalidating providers for continued participation in the Medi-Cal program. The Affordable Care Act of 2010 and the 42 Code of Federal Regulations, Section 455.414, require revalidation of enrollment for all provider types at least every five years.

In order to revalidate your eligibility for continued enrollment as a provider in the Medi-Cal program, you must submit the enclosed Revalidation Intent Notice within 35 days of the date of this notice. This written notification is being mailed to the business address and mailing address on file with the DHCS, as required in the CCR, Title 22, Section 51000.55(b).

Please complete the enclosed Revalidation Intent Notice and return within 35 days of the date of this notice to the address below. Faxed copies will not be accepted.

Department of Health Care Services  
Long-Term Care Division  
In-Home Operations Branch  
Attention: J. J. Woods  
MS 4502, P.O. Box 997437  
Sacramento, CA 95899-7437

Failure to complete and return the Revalidation Intent Notice within 35 days of the date of this notice will be treated as a decision not to continue as a Medi-Cal provider and the DHCS will deactivate each business address you use to provide services, goods, supplies, and merchandise to Medi-Cal beneficiaries. Should deactivation occur, the DHCS will inform you of the termination of enrollment.

# REVALIDATION INTENT NOTICE

## PROVIDER'S ENROLLMENT INFORMATION IS REQUIRED ON THIS INTENT NOTICE

**Mark the appropriate box(es) below:**

I intend to continue to participate in the Medi-Cal program.

I have been revalidated by Medicare, another State Medicaid or CHIP within the previous 12 months, please see attached proof of verification.

I intend to continue to participate in the Medi-Cal program; however, my enrollment information has changed.

I do not want to continue to participate in the Medi-Cal program. Please terminate my continued participation in the Medi-Cal program and deactivate the NPI number listed below. (Please complete form and sign below.)

I will complete and return the application packet via hard copy only. Please send a full application packet to my service address as provided below.

To continue to participate in the Medi-Cal program, please complete the following information and mail **(DO NOT FAX)** to: Department of Health Care Services, Long-Term Care Division, Attention: J. J. Woods, MS 4502, P.O. Box 997437 Sacramento, CA 95899-7437.

Provider's NPI Number: \_\_\_\_\_

Provider's Tax ID Number: \_\_\_\_\_

Provider's Legal Name: \_\_\_\_\_

Provider's Business Name: \_\_\_\_\_

Professional License/Certificate Permit Number: \_\_\_\_\_

Provider's Service Address: \_\_\_\_\_

Provider's Mailing Address: \_\_\_\_\_

Provider's Pay-to Address: \_\_\_\_\_

Provider's Business Telephone: \_\_\_\_\_

Provider's Email Address: \_\_\_\_\_

Contact Person Name and Telephone Number: \_\_\_\_\_

I declare under penalty of perjury under the law of the State of California that the foregoing information is 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.

\_\_\_\_\_  
Print Legal Name of Provider

\_\_\_\_\_  
Original Signature (in ink)

\_\_\_\_\_  
Print Name of Person Signing this Intent Notice

Executed at: \_\_\_\_\_ on \_\_\_\_\_  
City State Date