



Signing an Application in PAVE



Signing a PAVE Application

- To sign a PAVE application you must be legally authorized to sign the application
 - This is an individual who is the sole proprietor, partner, corporate officer, or by an official representative of a governmental entity or non-profit organization, who has the authority to legally bind the applicant
 - For group applications, an approved Medi-Cal Delegated Official, can sign the group section of the affiliation section only.
- You must be logged into PAVE with your User ID, utilizing your own email and password
- You must have a role in PAVE that is allowed to sign



Signing a PAVE Application

PAVE PORTAL SD Pharmacy James

Content

Getting Started

Business Information

Practice Information

Disclosure Information

Claim Payment

Application Fee

Signature

Electronic Signature

Submit Application

Declarations

E-Signature

Summary

You're almost ready to sign your application!

Even though you're completing and submitting your application through PAVE Portal and not on paper, your signature is still required. Using the electronic signature feature, you can submit this application just like your handwritten signature.

Please read the Medi-Cal Provider Agreement declarations below and then check the boxes to declare that you agree with this process.

Please note that in order to continue with the E-Signature process, you must read the Provider Agreement.

[Medi-Cal Provider Agreement](#) value is required

☐ I, **James Boyd**, declare that I have legal authorization to sign this application for and on behalf of **SD Pharmacy**. value is required



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Preview Medi-Cal Provider Agreement

View 1 of 15

MEDI-CAL PROVIDER AGREEMENT

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. Term and Termination. This Agreement will be effective from the date applicant is

Please note that in order to continue with the E-signature process, you must read the Provider Agreement.



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[Medi-Cal Provider Agreement](#) value is required

☒

I, **James Boyd**, declare that I have legal authorization to sign this application for and on behalf of **SD Pharmacy**.

☒

I, **James Boyd**, have read, understood and agree to the terms of the Medi-Cal Provider Agreement.

☒

I, **James Boyd**, have reviewed my application and believe all information and attachments are correct, to the best of my knowledge.

☒

I, **James Boyd**, 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, Section 51000.30.

← Previous

Continue →



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PAVE PORTAL

SD Pharmacy

James

ContentExpand All

Getting Started

Business Information

Practice Information

Disclosure Information

Claim Payment

Application Fee

Signature

Electronic Signature

Submit Application

DeclarationsE-SignatureSummary

To continue with the e-Signature process, I need to verify your personal information.

After agreeing to the declaration, make sure your Social Security Number and Date of Birth **are identical** to what you entered in the **Personal Information** section of the **Ownership/Control Interest** sub-form.

Please treat this section the same way as if you were using your PIN at an ATM.

If you need help with this section, please watch this In-Context Tutorial about e-signing an application.

☒ I, **James Boyd**, certify that I intend for my electronic signature on this application to be a legally binding equivalent of my traditional handwritten signature.

SSN (last 4 digits)###-##-###5

Year of birth###/###/###9

Email addressJamesBoyd@msn.com

Password.....

Previous







Continue


2/15/2019

6












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**PAVE PORTAL**SD PharmacyJames



Provider Name	SD Pharmacy	98% Complete	100% Documents	New Message	Submit Section
Provider Type	Pharmacy	98%	100%		
Application ID	192TQRID				
Creation Date	02/14/2019				
Package Type	Other Healthcare Business				

Content	Expand All
Getting Started	●
 Business Information	●
 Practice Information	●
 Disclosure Information	●
 Claim Payment	●
 Application Fee	●
 Signature	●
 Submit Application	●
 Checklist	●
 Submit	○

Submit Application



Nice job James Boyd! I am impressed. Now your application is ready to be submitted for approval. Remember that **once submitted, you cannot make any changes** to this application.

Submit Application

Previous



PAVE ON!