HEALTH CARE PROVIDER APPLICATION

Important: Please follow all instructions when completing the application.

- Type or print clearly, in ink.
- If you must make print corrections, strike a line through, date, and initial in ink.
- Do not use staples on this form or any attachments.
- Items marked with * are required fields.
- Enter N/A if not applicable. Do not leave any lines blank.
- Return completed application (including attachments) by mail to: Department of Rehabilitation, Medical Services Unit, P.O. Box 944222, Sacramento, CA 94244-2220, or by fax to: (916) 558-5441, or by email to: Medsvs@dor.ca.gov.
- More information can be found on the DOR website, https://www.dor.ca.gov/Home/HealthCareProvider.

ORGANIZATIONAL INFORMATION

Provider Name (as listed with the IRS)*:		Website Address:
Business Name, *if different**:		Service Contact Person*:
Doing Business As Name, *if different**:		Email Address:
Business Service Address*:		Billing Contact Person, *if different than above*:
		Email Address:
Business Phone*:	Business Fax:	Additional languages spoken at your office:
Mailing Address, *if different from Business Service Address**:		Remittance Address, *if different from Business Service Address**:

Satellite Offices, *if any operating under the same Taxpayer Identification Number and Business Name*

Address: Phone:	Address: Phone:	Address: Phone:

PROVIDER INFORMATION

License Number*:	License Effective Date*:	License Expiration Date*:
Individual Medi-Cal Number:	Individual Medi-Care Number:	Individual NPI:
Group Medi-Cal Number:	Group Medi-Care Number:	Group NPI:
DEA Number:	DEA License Expiration Date:	

SERVICE INFORMATION (Include any certified specialties)*

Medical, Podiatric, and Osteopathic Medicine
- ☐ Cardiology
- ☐ Dermatology
- ☐ Ear, Nose, and Throat
- ☐ Endocrinology
- ☐ General Medicine
- ☐ Internal Medicine
- ☐ Neurology and Neuromuscular
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Orthopedics
- ☐ Podiatry
- ☐ Psychiatry
- ☐ Surgery (list specialty):_____
- ☐ Urology
- ☐ Other Specialty:_____

Dental
- ☐ Dentist ☐ Oral Surgeon ☐ Orthodontist
- ☐ Periodontist

Hearing and Speech
- ☐ Aids & Devices ☐ Audiology
- ☐ Speech and Language Pathology

Durable Medical Equipment
- ☐ Services ☐ Equipment

Orthotics and Prosthetics
- ☐ Services ☐ Devices

Vision
- ☐ Optometry ☐ Low Vision
- ☐ Low Vision Aids

Psychology
- ☐ Psychology ☐ Neuropsychology

Other, please note: _____

Additional Specialty
- ☐ Alcohol and Drug Services
- ☐ Anesthesiology
- ☐ Immunizations/Vaccines
- ☐ Medical Supplies or Medication
- ☐ Occupational Therapy
- ☐ Pathology and Laboratory
- ☐ Physical Therapy
- ☐ Radiology

ATTACHMENT CHECKLIST (Provide copies of the following documents)*

- ☐ Brief Curriculum Vitae
- ☐ Payee Data Record – Std. 204
- ☐ CA Department of Consumer Affairs license verification: https://search.dca.ca.gov/
- ☐ Sellers Permit (in-state seller) or Certificate of Registration (out-of-state seller), if applicable

CERTIFICATION AND AGREEMENT*

I hereby certify that:

I am a Medi-Cal program provider or a licensed practitioner who meets the standards for participation in the Medi-Cal program specified in Title 22, CCR, Division 3, Chapter 3, Article 3, commencing with section 51200. I have not been denied, disqualified from, or currently am not suspended from participation in the Medi-Cal program.[1]

I agree to:

- directly render services to applicants and clients.[1]
- complete reports that meet the needs of the District Office within the time frames specified. [1]
- accept the Department's and/or similar benefit sources' fees as payment in full for the services rendered. [1]

[1.] Title 9, CCR, Division 3, Chapter 8, Article 2, Sections 7295 and 7295.5

By submitting this application, I declare that the foregoing information in this document and in the attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I am an authorized representative of this health care entity and I have the authority to legally bind this health care entity seeking enrollment on the DOR Health Care Provider Panel. I agree to provide documentation regarding any change in licensure or Medi-Cal provider status within 30 days of the effective date of such change.

Signature: ✍	Date:
Print Name:	

All information requested on the application and attachments is required by the Department of Rehabilitation (DOR), Medical Services Unit, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying mandatory information requested include potential denial of enrollment as a DOR Health Care Panel Provider or denial of continued enrollment and deactivation of reimbursement from DOR.

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, 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 other federal, state, or local agencies as appropriate.

Individuals / entities have the right to access records containing personal information. DOR's Medical Services Unit manages health care provider records and can provide information upon request. More information on accessing public records can be found on the DOR website, https://www.dor.ca.gov/Home/PublicRecordsRequests.