CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Michelle Baass | Director

Out-of-State Provider Express Enrollment Form

Dear Out-of-State Provider, in order to enroll as an out-of-state Medi-Cal provider, the following information is required: (Please attach this form to your original claim and mail in.)

Provider/Facility Name:_____

Ambulance – circle one:	**circle one:
Air Ground	M.D. D.O.

ATTENTION: _____
(If you have a hospital or clinic name)

Service Address: _____

City, State, ZIP: _____

"Pay to" Address, if different (include city, state and ZIP):

_____

ATTENTION:_____
(If you have a second name for your facility or billing company)

National Provider Identifier (NPI):_____

**License Number: _____

**License Issue Date: _____ Exp. Date: _____
(DD/MM/YY) (DD/MM/YY)

**Social Security Number: _____

Federal Tax ID Number: _____

Business Telephone: (___) _____

Please attach this letter to your claim form with the requested billing information and send to:

CALIFORNIA MMIS FI, OUT-OF-
STATE UNIT P.O. BOX 15507
SACRAMENTO, CA 95852-1507
(916) 636-1960

Please disregard this letter if you have already submitted an enrollment form.

**Individual Practitioners Only

For online Medi-Cal provider manuals, access: *www.medi-cal.ca.gov*