

INSTRUCTIONS FOR COMPLETION OF THE CROSSOVER ONLY PROVIDER FORM

DO NOT USE staples on this form or on any attachments.

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.

DO NOT LEAVE any question, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Omission of any information on this form, or the failure to provide the requested documentation or sign this document may result in a significant delay in the authorization of your request.

You must attach a copy of your Centers for Medicare and Medicaid Services (CMS) approval letter. Authorization to submit claims for reimbursement of cost sharing amounts cannot be given without it.

This “Crossover Only Provider Form” is solely for providers who render services to dual-eligible beneficiaries and who are not enrolled in Medi-Cal. A dual-eligible beneficiary is a beneficiary who is eligible for both Medicare and Medi-Cal. A provider would fill out this form if they are requesting authorization to bill Medi-Cal for Medicare cost sharing amounts. In order to use this form, the provider must meet all of the following conditions:

- The provider must be Medicare enrolled.
- The provider must have provided services to a dual-eligible beneficiary. This means that a provider must have provided services to a person who is both Medicare eligible and Medi-Cal eligible.
- The provider is requesting a **new authorization** to submit claims for reimbursement for services provided to a dual-eligible beneficiary, the provider would like to inform the Department of Health Care Services (DHCS) of a **change to previously submitted information** OR the provider is requesting the **deactivation of an authorization** previously granted by DHCS.

Unless all of the above statements apply, a provider is not eligible to use the “Crossover Only Provider Form.” If a provider wishes to be enrolled in Medi-Cal then they must submit a complete Medi-Cal application package. If you are an existing Medi-Cal provider and you wish to add a Medicare number to your existing file, you will need to complete and submit a Medi-Cal Supplemental Changes (DHCS 6209) form available at www.medi-cal.gov Provider Enrollment link.

Instructions

Enter the date you are completing the form.

NPI— Include the current NPI for the business address indicated in 3a.

Previously Submitted NPI Number— Only provide if your NPI has changed since your last request was submitted.

PTAN— Include your PTAN number assigned by the Centers for Medicare and Medicaid Services (CMS). Please attach a copy of your CMS approval letter.

Action requested — Check the action that applies to your request. “New request”— Check if this is the first time you are requesting authorization to bill for services provided to a dual-eligible beneficiary and you have not previously received a letter from DHCS explaining that you are authorized to bill OR if you have previously submitted a request for deactivation and the request for deactivation was processed by DHCS.

“Change to previously submitted information”— Check if you have previously submitted this form to DHCS and you are requesting a change to the information previously provided to DHCS.

“Deactivation” — Check if you are requesting a deactivation of your file.

I. Professional Information

“Type of entity”— Check the box which identifies your business structure. If your business structure is not listed in the options given, check the “other” box and enter your business structure.

1a. “Legal name of provider”— Enter the name listed with the Internal Revenue Service (IRS).

1b. “Previously submitted legal name” — If you have changed your legal name with the IRS, enter your new name in item 1a and your previous name in item 1b.

2a. “Business name”— Enter the business name if different than the legal name indicated in item 1a.

2b. “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.

2c. “Previously submitted business name” — Enter your former business name if applicable.

- 2d. “Previously submitted business telephone number” if applicable. Enter your new business name in item 2a and your new business telephone number in 2b if applicable.
- 3a. “Business address”— Enter the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code.
- 3b. “Previously submitted business address”— Enter the previous business location if your business has moved. Provide the new business address in 3a.
- 4a. “Pay-to address” is the address at which the provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
- 4b. “Previously submitted pay-to address” — If you wish to change your pay- to address on file, enter the new pay-to address in item 4a and your previous pay-to address in item 4b.
- 5a. “Mailing address” is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence.
- 5b. “Previously submitted mailing address” — If you wish to change your mailing address on file, enter your previous mailing address in 5b and your new mailing address in 5a.
- 6a-6c. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
- 6d. If there has been a change in your primary taxonomy code since your last form was submitted, provide the previously submitted taxonomy code in item 6d and the new primary taxonomy code in 6a
- 7a. Enter the Taxpayer Identification Number (TIN). A TIN is an identification number used by the IRS in the administration of tax laws. Examples of TINs are the following: Employer Identification Number (EIN), Individual Taxpayer Identification Number (ITIN), Social Security Number (SSN). If you do not have an EIN or an ITIN, then provide your SSN in 7c. If you are using an EIN, attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification) and provide that number in 7a. If you are using an ITIN, attach a copy of your IRS ITIN notification letter.
- 7b. If applicable, enter previously submitted TIN issued by the IRS.
- 7c. If you do not have an EIN or an ITIN, enter your SSN.
8. Enter your provider type. “Provider Type” refers to the type of professional service you provide to beneficiaries. Examples of provider types include but are not limited to the following: Physician, Chiropractor, Podiatrist, Medical Transportation Provider, Pharmacy, Psychologist, Speech Therapist, Optometrist.
- 9a. If you have a professional license, enter your professional license number.
- 9b. Enter the state of issuance for the professional license.
10. Enter other information you wish to provide to DHCS. If you would like to explain an entry on the form, provide that explanation in this box.

II. Signature

1. Print name of the provider signing the form.
2. Print name of representative if provider is a business entity.
3. Provide an original signature of the provider or representative. Include the city, state, and the date where and when the form was signed.
4. To assist in the processing of the Crossover Only Provider Form, enter the name, e-mail address, and telephone number of the individual who can be contacted by Provider Enrollment staff to answer questions regarding the form. Failure to include this information may result in a significant delay in the processing your request.

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

- Centers for Medicare and Medicaid (CMS) Approval Letter
- TIN (EIN, ITIN verification)



CROSSOVER ONLY PROVIDER FORM

Important:

- Read all instructions before completing the form.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- **Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.**

FOR STATE USE ONLY

Return completed form to:

Department of Health Care Services
 Provider Enrollment Division
 MS 4704
 P.O. Box 997412
 Sacramento, CA 95899-7412
 (916) 323-1945

Unless all three of the statements below apply to you, you are not eligible to use this form and must submit a complete application package.

1. I am a Medicare enrolled provider.
2. I have provided services to a dual-eligible beneficiary. (see instructions for definition)
3. I am requesting authorization to submit claims for reimbursement for services provided to a dual-eligible beneficiary, requesting a change to previously submitted information or I am requesting a deactivation of my provider file.

DATE: _____

NPI used for billing Medicare:	Previously submitted NPI (if applicable):
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PTAN (Medicare Identification Number): _____

(Attach a copy of your Centers for Medicare and Medicaid Services [CMS] provider approval letter.)

Action requested (check if applicable)

New request

Change to previously submitted information

Deactivation of provider file

I. PROFESSIONAL INFORMATION

Type of entity

Sole Proprietor (unincorporated) Partnership Nonprofit Corporation—Type of nonprofit: _____

Professional Medical Corporation—Corporate Other: _____

Number: _____

1a. Legal name of provider (as listed with the IRS) _____

1b. Previously submitted legal name (if applicable) _____

2a. Business name, if different from legal name	2b. Business telephone number ()
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2c. Previously submitted business name (if applicable)	2d. Previously submitted business telephone number (if applicable) ()
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3a. Business address (number, street)	City	County	State	Nine-digit ZIP code
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3b. Previously submitted Business address (number, street) (if applicable)	City	County	State	Nine-digit ZIP code
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4a. Pay-to address (number, street)	City	State	Nine-digit ZIP code
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4b. Previously submitted pay-to address (number, street) (if applicable)		City	State	Nine-digit Zip code
5a. Mailing address (number, street)		City	State	Nine-digit ZIP code
5b. Previously submitted mailing address (number, street) (if applicable)		City	State	Nine-digit ZIP code
6a. Primary Taxonomy Code	6b. Taxonomy Code	6c. Taxonomy Code		
6d. Previously submitted taxonomy code (if applicable)				
7a. Taxpayer Identification Number (EIN, ITIN) (attach copy of EIN verification or ITIN notification letter)	7b. Previously submitted TIN (EIN, ITIN) (if applicable)	7c. Social Security Number (if applicable)		
8. Provider Type (see instructions)	9a. Professional license number (if applicable)	9b. Professional license state of issuance		
10. Explanations or other information you wish to provide (attach additional pages if needed)				

II. Signature

1. Printed legal name (last) (first) (middle) (Jr., Sr., etc.)

2. Printed name of representative (if an entity or business name is checked above) (last) (first) (middle) (Jr., Sr., etc.)

3. Original signature of provider or representative (if this provider is an entity other than an individual or sole proprietor)

Executed at: _____, _____ on _____
 (city) (state) (date)

4. Representative/ Contact person's information

Contact person's name (last) (first) (middle) (gender)
 male female

Title/Position E-mail address Telephone number
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