

Billers: Medi-Cal Hardcopy Biller Application Agreement

Type of Request

_____ Initial submitter number

_____ Addition/Deletion of Provider to Submitter No. _____

Billing Service: _____

Billing Service Address: _____

Previously assigned submitter number (if applicable): _____

List Medi-Cal providers contracted with service agency:

<u>Provider Name</u>	<u>Provider Number</u>	<u>Effective Date</u>
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Authorized Applicant's Original Signature _____

Date: _____

This form is to be completed and returned to:

Department of Health Care Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413