



MICHELLE BAASS  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



GAVIN NEWSOM  
GOVERNOR

Dear Provider:

Thank you for your recent request for the *Medi-Cal Supplemental Changes* form, *DHCS 6209 (Revised 11/2021)*. Please complete the enclosed form and return it to:

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

Please read all the instructions included in the *Medi-Cal Supplemental Changes* form carefully and complete each item requested. Incomplete forms will be returned.

**PLEASE NOTE:** Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Applicants are required to attach a copy of the Centers for Medicare & Medicaid Services (CMS)/National Plan and Provider Enumeration System (NPES) confirmation for each NPI listed in the application package. If providers are not eligible to receive an NPI, they should instead enter the word “atypical” in any NPI fields. These “atypical providers” will receive a unique Medi-Cal provider number once the application is approved.

It is your responsibility to report to DHCS any modifications to information previously submitted within 35 days from the date of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* form. However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, a change of business address or one of the other changes identified in California Code of Regulations (CCR), Title 22, Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Medi-Cal Provider Enrollment page at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). The Provider Enrollment page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled provider or business, including the option to submit a *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217).

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or submit your question(s) using the [Inquiry Form](#).

Please visit the Medi-Cal Provider website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) for information on submitting claims electronically. A submitter number is not transferable. A new submitter number must be obtained each time a new Medi-Cal provider number is issued by DHCS. If you have any questions about obtaining an electronic billing submitter number, call the Telephone Service Center at 800-541-5555 and select the option for Computer Media Claims.

Provider Enrollment Division

Enclosures  
(Revised 11/2021)

## INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL SUPPLEMENTAL CHANGES

**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.

This form is a means to inform the Department of Health Care Services (DHCS) of any changes to previously submitted provider information and documentation. Applicants or providers may be subject to an on-site inspection prior to enrollment.

**Omission of any required information or documentation on this form, including not signing the form may result in your records with Medi-Cal not being updated as requested.**

**You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for any National Provider Identifier (NPI) added with this form. Any change in an NPI for an enrolled location requires that the confirmation reflect the enrolled location's address. You may not submit an NPI for use in Medi-Cal billing unless that NPI is appropriately registered with CMS and is in compliance with all NPI requirements established by CMS at the time of submission.**

Enter the legal provider name as listed with the Internal Revenue Service (IRS).

Enter your provider number (NPI or Medi-Cal Dental provider number as applicable) in the space provided.

Enter the date you are completing the application.

Provider type: Enter your provider type in one of the boxes provided.

Action requested: Check the applicable action you would like made to the provider master file.

**“Deactivate provider number” will deactivate all enrolled locations using the provider number submitted. To deactivate an enrolled provider type or location, please attach a cover letter specifying the deactivation request.**

Please complete only those boxes necessary to provide the information you are adding, changing, or deleting or to complete the action requested. Be sure to complete boxes 40-45; complete box 46, if applicable.

### GENERAL INFORMATION

1. “Business name” – enter the name of the applicant or provider if different than legal name. If this is a fictitious business name, provide a copy of the Fictitious Business Name Statement or Fictitious Name Permit number and effective date.
2. “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.
3. “Pay-to address” – enter the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the number, street name, room, suite number or letter, P.O. box number, city, state, and nine-digit ZIP code. **An applicant or provider may assign only one pay-to-address per NPI. Please note, substance use disorder clinics may not use the DHCS 6209 to update their “Pay-to Address.”**
4. “Mailing address” – enter the address where the applicant or provider wishes to receive general Medi-Cal correspondence including Provider Bulletins and Provider Manual updates.
5. a. Insert the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA Certificate.  
b. Insert the State Laboratory License/Registration number. Attach a legible copy to the application.

6. Insert any additional NPI for the entity indicated in number 1. Attach CMS/NPPES confirmation for each. Providers not eligible to receive an NPI (atypical providers) must submit a Medicare billing number.
7. Insert the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
8. Insert any local business license, permit, or certificate numbers for any city and/or county where you conduct your business activities and attach legible copies to the application.
9. a. Insert the specialty code(s) to be added or deleted, if applicable (see Physician/Non-Physician Practitioner Specialty Codes on page 19).  
b. Insert the taxonomy code(s) to be added or deleted from your NPI. These taxonomy codes must already be registered with NPPES prior to submission to Medi-Cal. Attach additional sheets if necessary.

### **CHANGE OF OWNERSHIP OR CONTROL INTERESTS**

10. For a change of ownership or control interests of less than 50 percent, list the new ownership information in this space and submit Sections III and IV of the Medi-Cal Disclosure Statement (DHCS 6207) for all new owners, managing employees, or control interests. If there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Section 51000.15, since the information provided in the last complete application that was approved for enrollment, a complete application package must be submitted pursuant to California Code of Regulations, Title 22, Section 51000.30(b).

### **CHANGE IN HOURS OF OPERATION**

11. "Hours of operation"—enter the business days and hours the provider is available for service to Medi-Cal beneficiaries.

### **FOR DURABLE MEDICAL EQUIPMENT AND PHARMACY PROVIDERS ONLY**

12. Check the appropriate box indicating whether the applicant provides "custom rehabilitation equipment" and "custom rehabilitation technology services" to Medi-Cal beneficiaries. If you answer yes, check the appropriate box whether the applicant has on staff, either as an employee or independent contractor, or the applicant has a contractual relationship with, a "qualified rehabilitation professional" who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment.

"Custom rehabilitation equipment" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.

"Custom rehabilitation technology services" means the application of enabling technology systems designed and assembled to meet the needs of a specific person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate, the documentation of medical necessity, the selection, fit, customization, maintenance, assembly, repair replacement, pickup and delivery, and testing of equipment and parts, and the training of an assistant caregiver and of a patient who will use the equipment or individuals who will assist the patient in using the equipment.

“Qualified rehabilitation professional” means an individual to whom any one of the following applies:

- (a) The individual is a physical therapist licensed pursuant to the Business and Professions Code, occupational therapist licensed pursuant to the Business and Professions Code, or other qualified health care professional recognized by the Department.
  - (b) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers, or other credentialing organization recognized by the Department.
  - (c) The individual has successfully passed one of the following credentialing examinations administered by the Rehabilitation Engineering and Assistive Technology Society of North America:
    - (i) The Assistive Technology Supplier examination.
    - (ii) The Assistive Technology Practitioner examination.
    - (iii) The Rehabilitation Engineering Technologist examination.
13. Enter the change in the business activity you are adding and the licensing information, if applicable. Complete and submit question 21 of the Medi-Cal Pharmacy Provider Application (DHCS 6205) or question 24 of the Medi-Cal Durable Medical Equipment Provider Application (DHCS 6205). Attach legible copies of any licenses, certificates, or permits required. If you have questions regarding the Bureau of Home Furnishings license, please call the Bureau at (916) 574-0280; or for the Home Medical Device Retailers license call the Food and Drug Branch at (916) 650-6518. To calculate percentages of business activities, refer to the Medi-Cal Durable Medical Equipment Provider Application (DHCS 6201). If deleting incontinence medical supplies, check the box.
14. Check the appropriate boxes and complete all requested information.

**FOR TRANSPORTATION PROVIDERS ONLY**

15. “Geographic Area(s) Served” - enter those areas in which the provider will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit with the application. If the city/county does not require a license/permit, you must attach a letter from that city/county with the application which states the city/county does not require a license/permit. It is the applicant’s or provider’s responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver’s permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver’s permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.
16. Provide the following information and attach legible copies, if applicable:
- Ambulance:
- Certificate number issued by the California Highway Patrol (CHP) - attach a legible copy of the certificate to the application
  - Issue date
  - Vehicle Identification Number (VIN) of each vehicle that will be used to transport beneficiaries
  - Make and model of vehicle
  - Year of vehicle
  - License plate number of vehicle
  - EMS verification

Driver:

- Full legal name of driver
- Driver's license number
- Driver's license year of expiration
- Ambulance Driver Certificate number
- MCSA-5875 and MCSA-5876 effective and expiration dates (for driver's only)

17. Provide the following information and attach legible copies, if applicable:

Aircraft:

- Certificate number issued by the Federal Aviation Administration (FAA) - attach a legible copy of the certificate to the application
- Name and address where the aircraft is hangared - This statement must also be on your company letterhead and be attached to the application
- EMS verification

Pilot:

- Full legal name of pilot
- Pilot's driver's license number or state issued identification card
- Pilot's license number with year of expiration
- Copy of FAA pilot's license for each pilot
- Copy of pilot's driver's license or state issued identification card

18. Provide the following information and attach legible copies, if applicable:

Vehicle Information (litter and/or wheelchair van or non-medical transportation vehicle):

- VIN of each vehicle that will be used to transport beneficiaries
- Photographs of vehicle (i.e., view of inside, back exit door, side exit door, and view of business name)
- Make and model of vehicle
- Year of vehicle
- License plate number of vehicle
- DMV vehicle registration
- Proof of vehicle insurance
- Brake and lamp certificate (litter and/or wheelchair van only)
- Special vehicle permit (if applicable)

Driver Information:

- Full legal name of driver
- Driver's license number
- DMV driving record printout for each driver
- Certificates for first aid and CPR for each driver
- Standard pre-employment drug and alcohol tests lab results for each driver
- California driver's license for each driver
- Special driver's permit (if applicable)
- MCSA-5875 and MCSA-5876 forms signed by authorized personnel for each driver

**FOR PHARMACIES ONLY**

19. Insert the last, first, and middle name of the pharmacist-in-charge at the business location.
20. Provide the social security number of the pharmacist-in-charge.
21. Insert the license number of the pharmacist-in-charge. Attach a legible copy of license renewal, if applicable.
22. Provide the driver's license or state-issued identification number and state of issuance of the pharmacist-in-charge. Attach a legible copy of the driver's license or state-issued identification card to this application.
23. - 28. Answer all questions as they pertain to the pharmacist-in-charge. If any answers are checked yes, list all details to include license number, dates, licensing agency, Medi-Cal provider information and numbers, etc., in number 29.
29. Provide all details to any yes answers for numbers 23 – 28 and attach supporting documents.

**PROVIDERS OF SUBSTANCE USE DISORDER TREATMENT SERVICES ONLY**

Substance Use Disorder Medical Director

30. Provide the following information and attach copies:
  - Full legal name
  - Provider Number (NPI)
  - Business address
  - Medical License Number (attach a legible copy of license)
  - Check whether the individual is being deleted or added as Medical Director at the business address indicated

Substance Use Disorder Treatment Professional/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Non-Physician Medical Practitioner/Other Physician Making Medically Necessary Determinations

31. Provide the following information and attach copies if applicable:
  - Full legal name
  - Provider Number (NPI) if applicable
  - Provider Type (see CCR, Title 22, Section 51051)
  - License, Certification, or Registration Number (attach a legible copy of license/certification/registration)
  - Check whether the individual is being deleted or added

Service Modality(ies)

32. Enter all services to be provided by the DMC clinic, including existing services and additional services or program types being requested by this application. Note – DMC residential services require a residential alcoholism or drug use recovery treatment facility license issued by DHCS. A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP or Heroin Detoxification services. If adding Heroin Detoxification services, please submit a Medi-Cal Provider Agreement (DHCS 6208). Facility licensing and NTP information and applications are available on the DHCS website.

33. Provide the requested information and attach a copy of the attestation letter(s) (see provider bulletin titled *Requirements and Procedures for Enrollment as a "Facility-Based Provider"*). Attach additional sheets if adding or deleting more than one facility.

### **NATIONAL PROVIDER IDENTIFIER (NPI) SUBPARTING**

34. See instructions for subparting information.

### **OTHER INFORMATION**

35. Check the appropriate box.
36. Provide all details regarding the addition(s) or change(s) if you answered yes to the previous question.
37. Check the appropriate box.
38. Provide all details regarding the addition(s) or change(s) if you answered yes to the previous question. (See CCR, Title 22, Sections 51000.30 and 51000.40).

### **INFORMATION ABOUT PROVIDER**

39. Printed name of provider signing this form - enter the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to DHCS for enrollment or continued enrollment as a provider in the Medi-Cal program.
40. Enter the date of birth of the individual named in number 39.
41. Check the gender of the individual named in number 39.
42. Provide the driver's license or state-issued identification number and state of issuance of the individual listed in number 39. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
43. Provide the social security number of the individual named in number 39. Provision of the social security number is required (see Privacy Statement page 18).
44. An original signature of the individual listed in number 39 is required. Also provide the title of the person signing the application who is the sole proprietor, partner, corporate officer, or by an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. Include the city, state, and the date where and when the application was signed. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this form.**
45. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

### Contact Person's Information

46. To assist in the timely processing of the supplemental form, enter the name, gender, title/position, e-mail address, and telephone number of the individual who can be contacted by staff to answer questions regarding the form. Failure to include this information may result in the supplemental form being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

**Attach a legible copy of the following, if applicable:**

- National Provider Identifier (NPI) verification (CMS/NPPES confirmation)
- Fictitious Business Name Statement or Fictitious Name Permit
- TIN verification
- CLIA Certificate
- State Laboratory License/Registration
- Seller's Permit
- Professional license, permit, or certificate
- Business license, permit, or certificate
- Licenses associated with business activities
- Bureau of Home Furnishings License
- Furniture and Bedding License
- Furniture License
- Bedding License
- Home Medical Device Retailer License
- Home Medical Device Retailer Exemptee License
- Other licenses, certificates, permits, etc.
- Pharmacist-in-Charge License
- Pharmacist-in-Charge driver's license or identification card
- Medical Director License
- Certificates for first aid and CPR for each new driver
- Driver's license for each new driver
- MCSA-5875 and MCSA-5876 forms signed by authorized personnel for each new driver
- Standard pre-employment drug and alcohol tests lab results for each new driver
- DMV driving history printout for each new driver
- Driver's license or identification card of person signing application
- Proof of insurance
- Brake and Lamp Certificate
- FAA certificate
- FAA pilot's license for each new pilot
- Signed Medi-Cal Disclosure Statement (DHCS 6207)
- Medicare enrollment verification
- Residential License issued by the DHCS
- Narcotic Treatment Program License issued by the DHCS
- Signed Medi-Cal Provider Agreement (DHCS 6208), if adding Heroin Detoxification services
- Substance use disorder medical director professional license
- Driver's license for each substance use disorder treatment professional, licensed substance use disorder treatment professional, substance use disorder non-physician medical practitioner providing counseling services, and physician making medical necessity determinations
- Facility-based provider attestation letter



**MEDI-CAL SUPPLEMENTAL CHANGES**

**For State Use Only**

**Important:**

- Read all instructions before completing the application.
- Type of print clearly, in ink.
- If you must make corrections, please line through, date and initial in ink.
- For Medi-Cal, return completed forms to:  
Department of Health Care Services  
Provider Enrollment Division  
MS 4704  
P.O. Box 997412  
Sacramento, CA 95899-7412  
(916) 323-1945
- For Medi-Cal Dental, return completed forms to:  
Medi-Cal Dental Program  
Provider Enrollment  
P.O. Box 15609  
Sacramento, CA 95852-0609  
(800) 423-0507
- **This is not the correct form for reporting a change in business address.**

Legal provider name (as listed with the IRS)	Provider number (NPI or Medi-Cal Dental provider number, as applicable)	Date
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**PROVIDER TYPE** (check one)

- |  |   |
|--|---|
| <input type="checkbox"/> Dentist                 | <input type="checkbox"/> Substance Use Disorder Clinic                    |
| <input type="checkbox"/> DME                     | <input type="checkbox"/> Physician  |
| <input type="checkbox"/> Laboratory              | <input type="checkbox"/> Provider Group                                   |
| <input type="checkbox"/> Orthotic and Prosthetic | <input type="checkbox"/> Registered Dental Hygienist Alternative Practice |
| <input type="checkbox"/> Pharmacy                | <input type="checkbox"/> Transportation                                   |
|  | <input type="checkbox"/> Other provider type (please describe)            |

\_\_\_\_\_

**ACTION REQUESTED** (check all that apply)

**Add:**

- Business Activity
- Clinical Laboratory Improvement Amendment (CLIA)
- Doing-Business-As (DBA) name
- Licenses, permits, certificates, etc.
- Transportation vehicle, driver or pilot
- Seller's Permit
- Medicare/Other NPI
- Specialty Code
- Taxonomy Code
- Facility(ies) (facility-based providers only)

**Delete:**

- Clinical Laboratory Improvement Amendment (CLIA)
- Transportation vehicle, driver or pilot
- Specialty Code
- Facility(ies) (facility-based providers only)

**Change:**

- NPI assigned to one or more locations – **see page 16**
- Address and/or phone (pay-to or mailing only)  
List any provider numbers the change is associated with: \_\_\_\_\_
- Transportation vehicle, driver, pilot or geographic area served
- Pharmacist-in-charge

**Change (continued):**

- Persons with ownership or control interest less than 50 percent
- Managing employee
- Hours of operation
- Business activities
- Other information previously submitted in an application package
- Service Modality(ies) (substance use disorder clinic only)
- Substance use disorder medical director (substance use disorder clinic only)
- Substance use disorder treatment professional, licensed substance use disorder treatment professional, or substance use disorder non-physician medical practitioner providing counseling services, or physician making medical necessity determinations (substance use disorder clinic only)

**Miscellaneous:**

PIN (Provider Identification Number)

- Issuance (new PIN)  
Note: Providers of substance use disorder treatment services may not use this form for PIN reissuance.
- Confirmation (existing PIN)
- Deactivate provider number:  
\_\_\_\_\_
- Deactivate provider type/location (attach letter specifying change)

**Complete only the boxes specific to the action requested. Complete boxes 39-44. Complete box 45, if applicable.**

**General Information**

1. Business name, if different		2. Business telephone number		
Is this a fictitious business name?  <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list the Fictitious Business Name Statement/Permit number (Attach a legible copy)		Effective date	
3. Pay-to address (number, street, suite and/or room, or P.O. Box number)	City	State	ZIP code (9-digit)	
4. Mailing address (number, street, P.O. Box number)	City	State	ZIP code (9-digit)	
5a. Clinical Laboratory Improvement Agreement (CLIA) (Attach a legible copy)	5b. State Laboratory License/Registration number (Attach a legible copy)	6. Medicare/Other NPI/Medicare Billing Number (see instructions)		

7. Seller's Permit number (Attach a legible copy)	8. Any local business license, permit, or certificate numbers (Attach a legible copy)	9a. Specialty code(s), if applicable  Add:                      Delete:
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9b. Taxonomy Codes (Attach additional sheets if necessary)

Add:			
Delete:			

10. **Change of Ownership or Control Interests** – For a change of less than 50% cumulative changes since last complete application approved for this provider number, list the new owner, managing employee, or control interest information and submit the Medi-Cal Disclosure Statement (DHCS 6207) Sections III and IV for all new owners, managing employees, or control interests.

Type of entity (check one)

<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> Partnership (Attach legible copy of agreement)	<input type="checkbox"/> Government Corporation	<input type="checkbox"/> Nonprofit	<input type="checkbox"/> Other: _____
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Are you adding owners, managing employees, or change in interest? If so, please provide the following information:

Name	Social security number	Date of birth	Title	Ownership percentage

Are you deleting owners? If so, please provide the following information:

Name	Social security number	Date of birth	Title	Ownership percentage

11. **Change in Hours of Operation**

The business days and hours of operation are:

Days: \_\_\_\_\_ Hours: \_\_\_\_\_

**For Durable Medical Equipment and Pharmacy Providers Only**

12. Do you provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries?  Yes  No

If yes, do you have on staff, either as an employee or independent contractor, or do you have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment?  Yes  No

13. **Change in Business Activities** – Complete and submit question 21 of the Medi-Cal Pharmacy Provider Application (DHCS 6205) or question 24 of the Medi-Cal Durable Medical Equipment Provider Application (DHCS 6201).

Add (please describe activities and percentages to equal 100%. Attach additional page):

If you are adding a business activity which requires any type of license, certificate, permit, etc., please list the information here and attach a legible copy of the license to this application:

Bureau of Home Furnishings License (see instructions):

Furniture and Bedding or Furniture Retailer License number (Attach a legible copy): \_\_\_\_\_

Registry number: \_\_\_\_\_

(If you are a DME provider and are renting beds, your license must bear a Registry number)

Issuance date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Home Medical Device Retailer License number (Attach a legible copy): \_\_\_\_\_

Issuance date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Home Medical Device Retailer Exemptee License number (Attach a legible copy): \_\_\_\_\_

Issuance date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Other license, certificate, permit, etc. (Attach a legible copy): \_\_\_\_\_

Delete incontinence medical supplies

14. Do you sell, rent, or lease durable medical equipment, incontinence medical supplies and/or supply items?  Yes  No

If yes, do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operation?  Yes  No

If no, please explain: \_\_\_\_\_

Are your equipment and/or supplies:

A. In stock on the premises, or

B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation: Days: \_\_\_\_\_ Hours: \_\_\_\_\_

If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code (9-digit)
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Who holds an ownership interest in the warehouse? (Use additional sheets if necessary)

Name	Telephone number		
Address	City	State	ZIP code (9-digit)

**For Transportation Providers Only**

15. Geographic area(s) served (list city/county – Attach a copy of permit/license)

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16. Ambulance and Driver Information – Attach ambulance certificate issued by CHP  
(Attach a separate sheet, if necessary)

**Ambulance Information**

CHP Certificate Number	Issue Date	Vehicle Identification Number	Make and Model of Vehicle	Year	License Plate Number	Add (✓)	Delete (✓)
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

Ensure legible copies of the following documents for each ambulance are attached to the application:

- CHP 301 Certificate       EMS Certificate, local       CHP 360A Ambulance license

**Driver Information (Attach a legible copy(ies) of driver’s license(s), MCSA-5875, MCSA-5876(s))**

Driver’s Name	Driver’s License Number	Year of Expiration	Ambulance Driver Certificate Number	MCSA-5875/5876 (Driver’s Only)		Add (✓)	Delete (✓)
				Eff. Date	Expiration Date		
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

17. Aircraft and Pilot Information – see instructions (Attach a separate sheet, if necessary)

**Aircraft Information**

FAA Certificate Number	Name and Address Where Aircraft is Hangared	Add (✓)	Delete (✓)
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Ensure a legible copy of the following document for each aircraft is attached to the application:

- FAA Certificate       EMS Certificate

**Pilot Information (Attach a legible copy(ies) of pilot’s license(s))**

Pilot’s Name	Driver’s License Number or State-Issued Identification Number	Pilot’s License Number	Year of Expiration	Add (✓)	Delete (✓)
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Ensure a legible copy of the following documents are attached to the application (as applicable):

- FAA pilot’s license for each pilot       Driver’s license or state-issued identification card

18. Vehicle and Driver Information – see instructions (Attach a separate sheet, if necessary)

**Litter and/or Wheelchair Van Vehicle Information**

Vehicle Identification Number	Make and Model of Vehicle	Year	License Plate Number	Add (✓)	Delete (✓)
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Ensure legible copies of the following documents for each vehicle are attached to the application:  
 DMV Vehicle Registration       Proof of Vehicle Insurance       Brake and Lamp Certificate       Special Vehicle Permit (if applicable)

**Non-Medical Transportation Vehicle Information**

Vehicle Identification Number	Make and Model of Vehicle	Year	License Plate Number	Add (✓)	Delete (✓)
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Ensure legible copies of the following documents for each vehicle are attached to the application:  
 DMV Vehicle Registration       Proof of Vehicle Insurance

**Driver Information**

Driver's Name	California Driver's License Number	Add (✓)	Delete (✓)
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Ensure legible copies of the following documents for each new driver are attached to the application:  
 DMV driving record printout       California Driver's License       MCSA 5875/5876  
 Certificates for first aid and CPR       Special driver permit (if applicable)  
 Standard pre-employment drug test (which lists the drugs tested for) and alcohol test lab results

**For Pharmacies Only**

**New Pharmacist-in-Charge (PIC)**

19. Printed name (last, first, middle)

20. PIC social security number (required)

21. PIC license number (Attach a legible copy of license and renewal, if applicable)

22. Driver's license or state-issued identification card number (Attach a copy)

State of issuance

If you answer yes to questions 23-28, give details to include license number, dates, licensing agency, Medi-Cal provider information and numbers, etc. in number 29 (see instructions)

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| 23. Has the PIC's individual license, certificate, or other approval to provide health care ever been suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Has the PIC's individual license, certificate, or other approval to provide health care ever been lost or surrendered?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does the PIC have an ownership or control interest in any other medical or Medi-Cal health care provider?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Has the PIC previously participated in the Medi-Cal program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Has the PIC ever participated in another State's Medicaid program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Has the PIC ever been suspended from a Medicare or Medicaid program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Details for questions 23-28 (Attach supporting documents, see instructions):  |                          |                          |

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**For Providers of Substance Use Disorder Treatment Services Only**

**Substance Use Disorder Medical Director\***

30.	Legal Name	Provider Number (NPI)	Business Address	Medical License Number (Attach a legible copy)	Add (✓)	Delete (✓)
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

**Substance Use Disorder Treatment Professional/Licensed Substance Use Disorder Treatment Professional\*/Substance Use Disorder Non-Physician Medical Practitioner\* Providing Counseling Services, or Other Physician Making Medical Necessity Determinations\***

(Attach additional sheets, if necessary)

31.	Legal Name	Provider Number (NPI, if applicable)	Provider Type	License, Certification, or Registration Number (Attach legible copy)	Add (✓)	Delete (✓)
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
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					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

*\*If the substance use disorder medical director, physician making medical necessity determinations, licensed substance use disorder treatment professional, or substance use disorder non-physician medical practitioner is not currently enrolled as such, a “Drug Medi-Cal Substance Use Disorder Medical Director/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Non-physician Medical Practitioner Application/Agreement/Disclosure Statement” DHCS 6010, must be submitted for the individual.*

**Service Modalities**

32. Identify the service modality(ies) and treatment component(s) (non-perinatal or perinatal) requested for the site. Include service modality(ies) and treatment component(s) that the provider wishes to continue as well as those to be added.

**Applicants for residential services must first obtain a residential license issued by the DHCS prior to application submission for DMC residential services. A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP or Heroin Detoxification services (Attach a copy of the NTP license). If adding Heroin Detoxification services, please submit a Medi-Cal Provider Agreement (DHCS 6208).**

Type of Services	Current and/or Requested Treatment Component	
Narcotic Treatment Program (NTP) License #: _____ (Attach a copy)	<input type="checkbox"/> Non-Perinatal	<input type="checkbox"/> Perinatal
Intensive Outpatient Treatment (IOT)	<input type="checkbox"/> Non-Perinatal	<input type="checkbox"/> Perinatal
Outpatient Drug Free (ODF)	<input type="checkbox"/> Non-Perinatal	<input type="checkbox"/> Perinatal
Residential License #: _____ (Attach a copy)	<input type="checkbox"/> Non-Perinatal	<input type="checkbox"/> Perinatal
Naltrexone	<input type="checkbox"/> Non-Perinatal	<input type="checkbox"/> Perinatal
Heroin Detoxification Program	<input type="checkbox"/> Non-Perinatal	<input type="checkbox"/> Perinatal

**For Facility-Based Providers Only**

33. Complete information below (Attach required attestation letter(s) for each licensed health care facility added. Attach additional sheets if adding or deleting more than one facility.)

Add Facility       Delete Facility      Telephone Number: \_\_\_\_\_

Legal Name of Licensed Health Care Facility: \_\_\_\_\_

Business Address of Facility: \_\_\_\_\_

NPI to be used by the Facility-Based Provider at this location: \_\_\_\_\_

Mailing Address to be used for this location: \_\_\_\_\_

Business Name to be used for this location: \_\_\_\_\_

Pay-to Address to be used for this NPI: \_\_\_\_\_

**National Provider Identifier (NPI) Subparting**

**General Subparting Instructions**

The table below is intended for applicants and providers who have subparted and wish to change an NPI assigned to one or more Medi-Cal enrolled locations. An applicant or provider must determine whether or not to subpart based on their business practices, billing practices and federal requirements including the NPI Final Rule.

A subpart is a component of a health care organizational provider, such as a provider group, that is not a person. A subpart furnishes health care and might:

- i. Conduct standard transactions
- ii. Be required by Federal regulations to have a Federal billing number (e.g., Medicare billing number)
- iii. Be certified/licensed separately from the covered organization
- iv. Have a location different from the covered organization
- v. Be a member of a chain
- vi. Be a DMEPOS provider

**If you are an individual sole proprietor (unincorporated) health care provider such as a physician, dentist, nurse, chiropractor, etc., you do not qualify to subpart.** When you receive your NPI you will be identified with an Entity Type Code 1 (Health care providers who are individual human beings, including sole proprietors).

**If you are an organization, you may subpart.** When you receive your NPI you will be identified with an Entity Type Code 2 (Health care provider who is other than an individual human being). Examples of organizations are hospitals; individuals who have incorporated; home health agencies; clinics; nursing homes; residential treatment centers; laboratories; emergency and non-emergency medical transportation companies; group practices; suppliers of durable medical equipment; prosthetics and orthotics providers; and pharmacies.

For additional information, please see the Centers for Medicare and Medicaid Services website for comprehensive information regarding subparting and general NPI implementation.

34. Subpart Designation Table

“Enrolled business location”—You must be currently enrolled at this location.

“NPI currently on file”—Indicate the NPI assigned to the enrolled business location at the time this form is submitted. “New NPI being assigned to the location”—Indicate the new NPI you wish to have assigned to the enrolled business location listed.

Enrolled Business Location			NPI currently on file	New NPI being assigned to the location
Number and Street	City	ZIP Code		

Attach additional sheets if necessary. Remember to attach verification of any new NPIs assigned. **Any change in an NPI for an enrolled location requires that the confirmation reflect the enrolled location’s address.**

**Other Information**

35. Are you reporting any addition(s) or change(s) in information to a pending application?  Yes  No

36. If you answer yes to the prior question, please explain:

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37. Are you reporting any addition(s) or change(s) in information submitted in a prior application other than information covered elsewhere in this form that does not require the submission of a new application package?  Yes  No

38. If you answer yes to the prior question, please explain:

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**Information About Provider**

39. Printed name (last, first, middle)	40. Date of birth	41. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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42. Driver's license or state-issued identification number and state of issuance (Attach a legible copy)	43. Social security number (Required, see privacy statement below)
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**44. I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR Section 51000.30(a)(2)(B).**

Signature of provider	Title
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Executed at: _____, _____ on _____ (City) (State) (Date)
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45. Notary Public – Please see instructions under number 45 for who must have their form signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

**46. Contact Person's Information**

Check here if you are the same person identified in number 39. If you checked the box, provide only the e-mail address and telephone number below.

Contact person's name (last, first, middle)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Title/Position	E-mail address
	Telephone number

**Privacy Statement (Civil Code Section 1798 et seq.)**

All information requested on the application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 - 14043.75, the California Code of Regulations, Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California state or local agencies as appropriate, fiscal intermediaries, managed care plans, 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 as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945 or contact Medi-Cal Dental at (800) 423-0507.

**PHYSICIAN/NON-PHYSICIAN MEDICAL PRACTITIONER SPECIALTY CODES**

Specialty	Code	Specialty	Code
Allergy	03	Pediatrics	40
Anesthesiology	05	Pharmacology-Clinical	91
Aviation (MD Only)	11	Physical Medicine & Rehabilitation	25
Cardiovascular Disease (MD Only)	06	Plastic Surgery	24
Clinics-Mixed Specialty	70	Proctology (Colon & Rectal)	28
Dermatology	07	Psychiatry	36
Emergency Medicine (Urgent Care)	66	Psychiatry-Child	26
Endocrinology	67	Public Health	44
Family Practice-House Calls	08	Pulmonary Diseases (MD only)	29
Gastroenterology (MD Only)	10	Radiology	30
General Practice (General Medicine)	01	Rheumatology	83
General Surgery	02	Surgery-Head & Neck	84
Geriatrics	38	Surgery-Traumatic	89
Hand Surgery	46	Thoracic Surgery	33
Hematology	68	Unknown	99
Infectious Disease	77	Urology, Urological Surgery	34
Internal Medicine	41		
Miscellaneous	47	<b>Specific to Osteopathic Physicians Onl</b>	
Neoplastic Diseases	78	Gynecology	
Nephrology (Renal-Kidney)	45	Manipulative Therapy	
Neurological Surgery	14	Ophthalmology, Otolaryngology, Rhinology	
Neurology (MD Only)	13	Pathologic Anatomy, Clinical Pathology	
Neurology-Child	79	Peripheral Vascular Disease or Surgery	
Nuclear Medicine	42	Psychiatry Neurology	
Obstetrics	15	Peripheral Vascular Disease or Surgery	
Obstetrics-Gynecology (MD Only) Neonatal	16	Radiation Therapy	
Oncology	78	Roentgenology, Radiology	
Ophthalmology	18		
Orthopedic Surgery	20	<b>Non-Physician Medical Practitioner</b>	
Otology, Laryngology, Rhinology (ENT)	04	Nurse Practitioner	
Pathology (MD Only)	22	Physician Assistant	
Pathology-Forensic	90	Nurse Midwife	
Pediatric Allergy	43		
Pediatric Cardiology (MD Only)	35		