INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL GROUP DESIGNATION OF DELEGATED OFFICIALS 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.

This form is for the purpose of adding or removing delegated officials to billing group enrollments.

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

Check box(es) to indicate if adding and/or removing delegated officials.

Enter the date you are completing the form.

A. Reporting Group Provider Identification Information

1. Enter the legal name of the group provider as listed with the Internal Revenue Service (IRS).
2. Enter the group provider's National Provider Identifier(s) (NPI).

B. Designation of Delegated Official(s)

Select the action requested for the delegated official and provide the effective date of the action.

3. Enter the full legal name of the delegated official (last, first, middle).
4. Enter the title or position that the delegated official holds within the organization.
5. Provide the full social security number of the delegated official. Provision of the social security number is required (see Privacy Statement on page 5).
6. Enter the date of birth of the delegated official.
7. Provide the driver's license or state-issued identification number and state of issuance of the delegated official. Attach a legible copy of the driver's license or state-issued identification.
8. Provide a telephone number for the delegated official.
9. Provide the e-mail address of the delegated official.
10. Provide the National Provider Identifier (NPI) of the delegated official, if applicable.
11. Enter the residence address (number, street, suite/apartment number), city, state, and nine-digit ZIP code of the delegated official.
12. Indicate if the individual in item 3 has an ownership or control interest in the group provider, is a W-2 employee of the group provider, or both.

13.-15. Answer each question. For any answer of yes, provide the date.

16.-28. Complete if adding or removing a second delegated official. Attach additional pages to add or remove more delegated officials, if needed.

29. Enter the full legal name of individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the group provider listed.

30. An original signature of the individual identified in item 29 is required. Stamped, faxed, and/or photocopied signatures are ***not*** acceptable. Also provide the title of the person signing the form.
31. 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 Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

MEDI-CAL GROUP DESIGNATION OF DELEGATED OFFICIALS FORM

For State Use Only

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.
- 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
- **Do not use staples on this form or on any attachments.**
- **Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.**

Action(s) requested: ☐ Add delegated official(s) ☐ Remove delegated official(s)	Date:

A. Reporting Group Provider Identification Information

1. Legal name of group provider (as listed with the IRS)	2. Group provider number(s) (NPI)

B. Designation of Delegated Official(s) – Attach additional sheets, if necessary

Delegated Official ☐ Add ☐ Remove Effective date (mm/dd/yyyy):

3. Printed legal name of delegated official (last, first, middle)	4. Title/Position

5. Social security number	6. Date of birth (mm/dd/yyyy)	7. Driver's license or state-issued identification number, state of issuance (attach a legible copy)

8. Telephone number	9. E-mail address	10. NPI (if applicable)

11. Residence address (number, street, ste)	City	State	ZIP code (9-digit)

12. This individual: ☐ has an ownership/control interest in the group provider
☐ is a W-2 employee of the group provider ☐ both

13. Within ten years from the date of this statement, has the individual listed in item 3 been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
    If yes, date of conviction (mm/dd/yyyy):

14. Within ten years from the date of this statement, has the individual listed in item 3 been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
    If yes, date of final judgment (mm/dd/yyyy):

15. Within ten years from the date of this statement, has the individual listed in item 3 entered into a settlement in lieu of a conviction for fraud or abuse involving any government program? ☐ Yes ☐ No
    If yes, date of settlement (mm/dd/yyyy):

Delegated Official ☐ Add ☐ Remove Effective date (mm/dd/yyyy):

16. Printed legal name of delegated official (last, first, middle)	17. Title/Position

18. Social security number	19. Date of birth (mm/dd/yyyy)	20. Driver's license or state-issued identification number, state of issuance (attach a legible copy)

21. Telephone number	22. E-mail address	23. NPI (if applicable)

24. Residence address (number, street, ste)	City	State	ZIP code (9-digit)

25. This individual: ☐ has an ownership/control interest in the group provider
☐ is a W-2 employee of the group provider ☐ both

26. Within ten years from the date of this statement, has the individual listed in item 16 been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
    If yes, date of conviction (mm/dd/yyyy):

27. Within ten years from the date of this statement, has the individual listed in item 16 been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
    If yes, date of final judgment (mm/dd/yyyy):

28. Within ten years from the date of this statement, has the individual listed in item 16 entered into a settlement in lieu of a conviction for fraud or abuse involving any government program? ☐ Yes ☐ No
    If yes, date of settlement (mm/dd/yyyy):

C. Authorized Official Certification and Signature

29. Printed name of the individual signing (last, first, middle)

A DELEGATED OFFICIAL means an individual who is delegated the authority to sign on behalf of the applicant or provider by an authorized official for situations as specified in the Provider Bulletin titled *Requirements and Procedures for Groups Designating Delegated Officials*. The delegated official must be an individual with ownership or control interest in, or be a W-2 employee of, the provider or applicant. An independent contractor cannot be a delegated official.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the entity's Medi-Cal enrollment information. The authorized official will still retain the authority to make changes and/or updates, even if a delegated official is appointed.

A provider or applicant is not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to enrollment information.

The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider or applicant to the laws, regulations, provider bulletins and program instructions of the Medi-Cal program.

By his or her signature on future affiliation forms, a delegated official certifies that the individual has read the Medi-Cal Provider Agreement, and all information in this Medi-Cal Group Designation of Delegated Officials Form and the Medi-Cal Rendering Provider/Group Affiliation/Disaffiliation Form (DHCS 4029) and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official as defined in *Requirements and Procedures for Groups Designating Delegated Officials*. The delegated official certifies under penalty of perjury that the information provided in submissions to the department is true, complete, and accurate.

The signature of an authorized official on this form constitutes a legal delegation of authority to all delegated official(s) assigned herein.

30. Original signature of authorized individual in item 29	Title	Date

31. **Notary Public** – Please see instructions under number 31 for who must have their form signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on this form 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 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.