Medi-Cal Eligibility Verification Enrollment Form

Page updated: August 2020

Important: The following provider information must match what is currently on file with the Department of Health Care Services (DHCS) Provider Enrollment Services, or the application will not be processed. Non-providers are not required to complete this form but may choose to receive the *Medi-Cal POS Network Interface Specifications* document by contacting the Point of Service (POS)/Internet Help Desk at 1-800-541-5555.

Provider Number _____

CMC Submitter Number (if applicable) _____

Name (full legal) _____

Service Address _____

_____

Ship-to Address (if different) _____

_____

City, State, ZIP_____

County_____

Contact Name _____

Phone Number (____) _____ _____

Note: The request will be mailed via United Parcel Service (UPS). Please note that deliveries cannot be made to a post office box.

Below, please choose the eligibility verification option that you desire. If you elect to use the Automated Eligibility Verification System (AEVS), **NO** action is necessary on your part (i.e., you do not need to return these forms).

Options (put a check mark in the appropriate space below):

☐ I have read, signed and attached the ***Medi-Cal Point of Service (POS) Network/Internet Agreement and the Medi-Cal Eligibility Verification Enrollment Form***. I understand and agree to comply with their terms and conditions.