California Children's Services (CCS) Program
INDIVIDUAL PROVIDER PANELING APPLICATION FOR PHYSICIANS AND PODIATRISTS

Return completed form to:
Department of Health Care Services
Children's Medical Services Branch
Provider Services Unit
MS 8100
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 322-8702

IMPORTANT:
- Fields 1–10 are **mandatory** and must be completed; enter N/A if not applicable.
- See attached instructions to complete this form.
- Type or print legibly.

Provider Type (Check one.) (See last page of instructions for CCS program participation requirements by Provider Type.)

☐ Physician ☐ Podiatrist

1. Legal name of applicant (last name)	(first name)	(middle initial)	2. Gender ☐ Male ☐ Female

3. Business address (office/hospital) (number, street)	City	County	State	ZIP code

4. Business telephone number ( )	5. Provider number	6. Professional license number (attach a copy)	Expiration date

7. a. Specialty(s)	b. Currently Practicing Yes	b. Currently Practicing No	c. Board Certified	c. Board Eligible	d. Name of Issuing Board(s) *Attach a copy of each board certificate. If board eligible, attach a copy of board eligibility documentation.*
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

8. a. Subspecialty(s)	b. Currently Practicing Yes	b. Currently Practicing No	c. Board Certified	c. Board Eligible	d. Name of Issuing Board(s) *Attach a copy of each board certificate. If board eligible, attach a copy of board eligibility documentation.*
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

9. **Additional Subspecialty and/or Pediatric Subspecialty Training**

a.	c.
b.	d.

Indicate any additional fellowship or pediatric fellowship training or experience for your subspecialty that does not currently have a certificate issued by the American Board of Medical Specialties, e.g., Ophthalmology, Cornea and External Disease, Pediatric Anesthesiology. Attach a copy of fellowship completion certificate.

10. Specify the hospital(s) where you have ***active*** admitting privileges. If you ***do not*** have ***active*** admitting privileges, list the health plan(s) in which you are currently credentialed and enrolled. Attach an additional sheet if necessary and label as number 10.

Name of Hospital/Health Plan	City

11. **This item applies *only* to Family Practice Physicians and Podiatrists.** Submit documentation of experience. (See last page of instructions for CCS program participation requirements for your provider type.)

For State Use Only

Reviewed by	Date	Panel effective date

I agree to:

A. Be enrolled as a provider in the Medi-Cal program with an active provider number.

B. Accept referrals, as my medical practice allows, of CCS applicants or clients who are Medi-Cal beneficiaries whose services are authorized by the CCS program.

C. Abide by the laws, regulations, and policies of the Medi-Cal and CCS programs.

D. Request prior authorization for services from the CCS program.

E. Accept payment from the Medi-Cal or CCS programs for medically necessary services as payment in full.

F. Not submit a claim to, or demand or otherwise collect reimbursement from, the CCS applicant or client or persons acting on behalf of the CCS applicant or client for any services authorized by the CCS program.

G. Obtain prior authorization (as applicable) from and bill the CCS applicant's or client's other health care coverage for services requested from CCS prior to billing the Medi-Cal or CCS programs whenever such other health care coverage exists.

H. Provide timely copies of written documentation for CCS authorized services rendered as requested by the CCS program.

I. Serve CCS applicants and clients regardless of race, religion, age, sex, color, national origin, or physical or mental disability.

I hereby affirm that the information submitted on this application, and any attachments, are true, accurate, and complete to the best of my knowledge and belief and is furnished in good faith.

Printed name of the applicant:

(First name) (Middle initial) (Last name)

Signature of the applicant in ANY COLOR OTHER THAN BLACK INK (first, middle initial, last)	**Date signed**

Privacy Statement

(Civil Code Section 1798 et seq.)

Any information provided will be used to verify eligibility to participate as a provider in the CCS program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Health Care Financing Administration, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Department of Health Care Services, CMS Branch, Provider Services Unit, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413, (916) 322-8702.

Did you remember to enclose (as applicable):

☐ Copy of Curriculum Vitae
☐ Copy of American Board of Medical Specialties certificate(s) or letter verifying board eligibility, if not board certified
☐ Copy of Professional License
☐ Copy of Fellowship Completion Certificate (if applicable)

INSTRUCTIONS FOR COMPLETING THE APPLICATION

For assistance, please call Children's Medical Services Branch, Provider Services Unit
(916) 322-8702

Physicians and Podiatrists require paneling by the CCS program to obtain an authorization to provide services for CCS clients.

Omission of any information or documentation on this application or the failure to appropriately sign this application may result in delays in or inability to process this application. You may be contacted if additional information and documentation is needed.

Provider Type: Check the appropriate box that describes the profession for which you are applying to be paneled by the CCS program.

1. Legal name of applicant means the name under which you are applying for paneling by the CCS program.

2. Check the appropriate box for your gender.

3. Business address means the office location where you render services, including the street name and number, room or suite number or letter, city, county, state, and 5-digit ZIP code. A post office box or commercial box is not acceptable.

4. Business telephone number means the primary business telephone number used at your business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the business telephone number.

5. Provide all of your ***active*** individual provider ***billing*** number(s).

6. Provide your California professional license number and expiration date. Attach a clearly legible copy to the application.

7. a. Provide the name of your specialty(s).
   b. Indicate yes or no as appropriate to identify the specialty you are currently practicing. Your information will be utilized for case management purposes on the paneled provider listing,
   c. Check the appropriate box if you are board certified or board eligible in the specialty.
   d. Indicate the name(s) of the Issuing board(s) and attach a clearly legible copy of the board certificate(s) or residency completion certificate or board eligibility documentation to the application.

8. a. Provide the name of your subspecialty(s).
   b. Indicate yes or no as appropriate to identify the subspecialty you are currently practicing. Your information will be utilized for case management purposes on the paneled provider listing.
   c. Check the appropriate box if you are board certified or board eligible in the subspecialty.
   d. Indicate the name(s) of the Issuing board(s) and attach a clearly legible copy of the board certificate(s) or residency completion certificate or board eligibility documentation to the application.

9. Indicate any additional fellowship or pediatric fellowship training or experience for your subspecialty that does not currently have a certificate issued by the American Board of Medical Specialties. PLEASE ATTACH A COPY OF THE CERTIFICATE OF FELLOWSHIP COMPLETION.

10. List the name and city of hospitals at which you have full, current, unrevoked, and unsuspended privileges at a Joint Commission for Accreditation of Healthcare Organizations or American Osteopathic Association accredited general acute care hospital. If you do not have hospital privileges, provide the names of the health plans with which your are credentialed and are currently enrolled as an active provider. Attach a separate sheet of paper to this application and label as item 10 if additional space is needed.

11. This item applies only to Family Practice Physicians and Podiatrists. On a separate sheet of paper attached to this application and labeled as number 11, provide the required documentation of pediatric experience as indicated for your Provider Type located on the last page of these instructions.

Signature Page
Print the first name, middle initial, and last name of the individual indicated in number 1.

Signature of the Applicant means the first name, middle initial, and last name of the individual indicated in number 1. An original signature ***IN ANY COLOR OTHER THAN BLACK INK*** is required. Indicate the date the application is signed.

CCS PROGRAM PARTICIPATION REQUIREMENTS BY PROVIDER TYPE

Physicians

1. Physicians must be:
   a. Licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California; and
   b. Certified by a member board of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists.
   c. Physicians who are not board certified but who are eligible for the certifying examination may participate in the CCS program for not more than three years. A verification letter of eligibility from the applicable member board is required. If the physician does not have a board verification letter, he or she shall submit other evidence regarding eligibility to take the board examination such as a letter from the Medical Director of his or her residency program verifying satisfactory completion of training.

2. Family practice physicians must meet the requirements of number 1 above and have documented experience treating children with CCS eligible medical conditions for at least five years, or have treated 100 or more such children.

   Documented experience means providing the CCS program with a list of cases indicated by a numeric value instead of a name, their CCS-eligible medical condition and the range of dates during which services were rendered. Do not provide the names of the children ***or any other specific identifiers in your report.***

Podiatrists

Podiatrists must meet all of the following requirements:

1. Be licensed to practice podiatric medicine by the California Board of Podiatric Medicine;
2. Be certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics; and
3. Have documented experience treating children with CCS-eligible medical conditions for at least five years, or have treated 100 or more such children.

   Documented experience means providing the CCS program with a list of cases indicated by a numeric value instead of a name, their CCS eligible medical condition, and the range of dates during which services were rendered. Do not provide the names of the children ***or any other specific identifiers in your report.***