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

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Durable Medical Equipment Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. This letter addresses information about the enrollment application process for a specific provider type.

PLEASE NOTE: Effective May 23, 2007, applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Current Medi-Cal providers will be required to submit both the NPI and any Medi-Cal provider numbers issued previously on any application forms submitted to the Department of Health Care Services (DHCS). Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation letter 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.

DHCS is not accepting enrollment applications from new providers of Durable Medical Equipment (DME) at this time. Currently, there is a 180-day moratorium on the enrollment of applicants as DME providers. This moratorium ends on August 25, 2007, and is in accordance with Section 14043.55 of the California *Welfare and Institutions Code* (W & I Code). As stated in the W & I Code, this moratorium may be extended or repeated when the DHCS Director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

This moratorium does not apply to:

1. Applicants who will be enrolled exclusively as Customized Wheelchair DME (CWDME) providers and/or Oxygen and Respiratory Equipment DME (OREDME) providers.

    a) CWDME providers shall sell, service and/or repair customized wheelchairs as medically necessary for Medi-Cal beneficiaries. An enrolled CWDME provider is authorized to provide the listed DME items in the Medi-Cal Provider Manual for wheelchairs, modifications and accessories.

    b) OREDME providers shall provide only items authorized in the Medi-Cal Provider Manual, under the Oxygen and Respiratory Equipment Group and deemed medically necessary for Medi-Cal beneficiaries.

2. Current Medi-Cal enrolled DME providers seeking to add a new business location so long as a provider enrolled in the program after October 12, 1999 is not adding new business activities, categories of service, or billing codes, other than those approved for enrollment at its existing location;

3. Applicants who will be enrolled solely for reimbursement for Medicare cost sharing amounts;

4. An application that is submitted because an existing Medi-Cal enrolled DME provider, which is part of a group of affiliated corporations (as defined by California Corporations Code, Section 150), is transferring its assets to another affiliated corporation that is a part of the same group of affiliated corporations;

5. An application that is submitted because an existing Medi-Cal enrolled DME provider, who is an individual operating as an unincorporated sole proprietorship, has incorporated that sole proprietorship, with all of the existing issued shares of the new corporation being owned by that individual who is also the president of the new corporation;

6. An application that is submitted because there has been a cumulative change of 50 percent or more in the person(s) with an ownership or control interest in an existing Medi-Cal enrolled DME provider, provided that the change only consists of a reorganization or consolidation among existing person(s) previously identified in the last complete application package that was approved for enrollment as having an ownership interest in the provider totaling 5 percent or greater;

7. Applications submitted pursuant to California Code of Regulations, Title 22, Section 51000.55 or Section 51006, Subparts (a)(1), (a)(2), (a)(3) or (a)(5);

8. Applications submitted pursuant to California Code of Regulations, Title 22, Section 51000.30(b)(3) provided that there is no change in the person(s) previously identified in the last complete application package that was approved for enrollment as having a control or ownership interest in the provider totaling 5 percent or greater;

9. Applications submitted pursuant to California Code of Regulations, Title 22, Section 51000.30(a) only because an existing Medi-Cal enrolled DME provider has changed its location; or,

10. Applicants that are the only person or entity in the United States that provides a specific product or service that is a Medi-Cal covered benefit.

If you are eligible according to the criteria outlined above, please complete a new application package consisting of a *Medi-Cal Durable Medical Equipment Provider Application* (DHS 6201, rev. 3/07 – DHCS 6201, rev. 7/07), a *Medi-Cal Disclosure Statement* (DHS 6207, rev. 3/07 – DHCS 6207, rev. 7/07), a *Medi-Cal Provider Agreement* (DHS 6208, rev. 3/07 – DHCS 6208, rev. 7/07) and any required attachments.

Return the completed application package to:

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

Please include with your application package a cover letter explaining in detail the circumstances that qualify your business as an exception to the current moratorium. If you cannot enroll at this time, please contact our office in August 2007 to ascertain the status of the moratorium.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned.

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 can be reported on a *Medi-Cal Supplemental Changes* form (DHS 6209, rev. 3/07 – DHCS 6209, rev. 7/07). 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 Title 22, CCR 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**. The Provider Enrollment Page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled DME provider or business, including the option to submit a *Successor Liability with Joint and Several Liability Agreement*.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms, form completion and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the “Provider Enrollment” link. If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or submit your question(s) to the address above or via e-mail at **PEDCorr@dhcs.ca.gov**.

In order to submit claims electronically, providers must request a submitter number by completing a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, rev. 7/07), available on the Medi-Cal Web site at **www.medi-cal.ca.gov** under "Provider Resources." Click the "Forms" link and select "Billing."

A submitter billing number for an existing DME provider is not transferable. A new submitter number must be obtained each time a new Medi-Cal DME provider number is issued by DHCS.

If you have any questions about completing the *Medi-Cal Telecommunications Provider and Biller Application/Agreement*, call the TSC at 1-800-541-5555 and select the option for Computer Media Claims.

Provider Enrollment Division

Enclosures (Revised 7/07)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL DURABLE MEDICAL EQUIPMENT PROVIDER APPLICATION

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 questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is part of an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a MEDI-CAL DISCLOSURE STATEMENT (DHCS 6207) and a MEDI-CAL PROVIDER AGREEMENT (DHCS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

Omission of any information or documentation on this form or failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation letters for each National Provider Identifier (NPI) submitted with your application package.

Enrollment action requested – check all that apply. Enter the date you are completing the application.

"New provider" – check if the applicant is not currently enrolled in the Medi-Cal program as a provider with an active provider number.

"Change of business address" – check if the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

"Additional business address" – check if the applicant is currently enrolled in the Medi-Cal program and is requesting enrollment for an additional business location.

"New Taxpayer ID number" – check if a new Taxpayer Identification Number (TIN) was issued by the IRS.

"Change of ownership" – check if there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

"Acceptance of Successor Liability with Joint and Several Liability" – check this box only if you are submitting this application pursuant to Title 22, CCR, Section 51000.32 and have already submitted or have enclosed a letter that meets the requirements of Section 51000.32(a)(1).

"Cumulative change of 50 percent or more in person(s) with ownership or control interest" – check if there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

"Sales of assets (50 percent or more)" – check if 50 percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

"Continued Enrollment" – check if the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current provider number(s).

Check the box labeled "I intend to use my current . . . ." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51.

"Type of entity" – check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check "other," list the type of legal entity.

1. "Legal name" is the name listed with the Internal Revenue Service (IRS).
2. "Business name" is the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application.

3. “Business telephone number” is 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.
4. “Business address” is the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office or commercial box is not acceptable.
5. “Pay-to address” is the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. “Mailing address” is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
8. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
9. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 8.)
10. Enter any local business license numbers or permits for any city or county, or city and county where you conduct your business activities and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
11. Enter any NPI registered with other carriers including, but not limited to Medicare. Attach a copy of the CMS/NPPES confirmation letter for each. Providers not eligible to receive an NPI (atypical providers) should submit a Medicare billing number.
12. Enter the Seller’s Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller’s Permit.
13. Check the appropriate boxes and complete all requested information in this section.
14. Check the appropriate boxes and complete all requested information in this section.
15. Check the appropriate boxes regarding your ownership and/or leasehold interest in the building in which your business is located. If you lease the building, attach a copy of the written lease agreement. If anyone other than you holds an ownership interest in the building, enter the name(s), phone number(s), and address(es) of that person(s).
16. Check the appropriate box regarding whether you have the administrative and fiscal foundation to enable your business to survive as a going concern.
17. Check the appropriate boxes and complete all requested information in this section.
18. Check the appropriate box to indicate whether you have the necessary equipment, supplies and facilities to carry out your business and to comply with Title 22, CCR, Section 51476.
19. Check the appropriate box and complete all requested information in this section.
20. Check the appropriate box and complete all requested information in this section.
21. Check the appropriate box and complete all requested information in this section.
22. Check the appropriate box indicating whether the applicant or provider provides “custom rehabilitation equipment” and “custom rehabilitation technology services” to Medi-Cal beneficiaries. If you answer yes, check the appropriate box whether the applicant or provider has on staff, either as an employee or independent contractor, or the applicant or provider 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, pick up 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 client 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 approved 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.

23. Check the applicable box(es) corresponding to all business activities of the applicant or provider and give the percentage of each of those activities. Attach copies of all applicable licenses and/or certifications. Total the percentages. The percentages must total 100 percent. Calculate percentages based upon total dollar sales, including Medi-Cal, Medicare, all other third party payors, and cash transactions for the year immediately preceding filing of this application. If a change of 20 percent or more in total business activity is anticipated within the next year, compared to business activity in the year immediately preceding the filing of this Application, adjust the percentage listings to reflect this anticipated change.

24. Proof of Liability Insurance—enter the name of the insurance company, insurance policy number, date policy issued, expiration date of policy, insurance agent's name, telephone number of the insurance agent, fax number of the insurance agent and email address of the insurance agent. You must attach a copy of your certificate of insurance for the identified business address to the application.

25. Check the appropriate box to indicate whether you have Worker's Compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.

26. "Printed name of provider." Enter the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Care Services for enrollment or continued enrollment as a provider in the Medi-Cal program.

27. Check the gender of the individual named in number 26.

28. Enter the driver's license or state-issued identification number and state of issuance of the individual listed in number 26. 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.

29. Enter the date of birth of the individual named in number 26.

30. Enter the social security number of the individual named in number 26. (Optional—see Privacy Statement on page 8).

31. An original signature of the individual named in number 26 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

32. 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.

✓ Remember to attach a legible copy of the following, if applicable:

❒ Fictitious Business Name Statement

❒ TIN verification

❒ Seller's Permit

- ❒ Any local business license numbers/permits
- ❒ Bureau of Home Furnishings and Thermal Insulation license
- ❒ Home Medical Device Retailer license
- ❒ Home Medical Device Retailer Exempted license
- ❒ Driver's license or state-issued identification card of individual signing the application
- ❒ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ❒ Signed Medi-Cal Provider Agreement (DHCS 6208)
- ❒ Medicare enrollment verification
- ❒ Successor Liability Agreement (If applicable)
- ❒ National Provider Identifier verification (CMS/NPPES confirmation letter)

MEDI-CAL DURABLE MEDICAL EQUIPMENT PROVIDER APPLICATION

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (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.

Enrollment action requested (check all that apply)

Date ____/____/____

❒ New provider

For any of the following actions, include current Medi-Cal provider number:
_____and/or NPI _____

❒ Change of business address
❒ Additional business address
❒ New Taxpayer ID number
❒ Change of ownership (per Title 22, CCR, Section 51000.6)
❒ Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
❒ Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
❒ Sale of assets (50 percent or more, per Title 22, CCR, Section 51000.30)

❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55)

❒ I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.
Indicate the change of ownership effective date: ____/___/_____

Type of entity (check one)

❒ Sole proprietor
❒ Corporation:
Corporate number:_____
State incorporated:_____

❒ Partnership (attach legible copy of agreement)
❒ Limited Liability Company (LLC):
LLC number: _____
State registered/filed: _____

❒ Government entity
❒ Nonprofit Corporation
Type of nonprofit: _____
❒ Other:_____

1. Legal name of applicant or provider (as listed with the IRS)

2. Business name, if different

3. Business telephone number
( )

Is this a fictitious business name?
❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement number

Effective date
/ /

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)

4. Business address (number, street)	City	County	State	Nine-digit ZIP code

5. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

7. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code

8. Taxpayer Identification Number (TIN)
(attach a legible copy of the IRS form)
____ ____ – ____ ____ ____ ____ ____ ____ ____

9. Social security number. If sole proprietor not using a TIN, you must disclose this number.
(See Privacy Statement on page 8.)
____ ____ ____ – ____ ____ – ____ ____ ____ ____

10. Any local business license numbers/permits (attach legible copies)	11. Medicare/Other NPI/Medicare Billing Number (attach a legible copy)	12. Seller's Permit number (attach a legible copy)

13. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies, and/or medical supply items? ..... ❒ Yes ❒ No

If no, please explain: _____

_____

Do you have adequate inventory and staff to meet both your current and your anticipated sales and service requirements? ..... ❒ Yes ❒ No

If no, please explain: _____

_____

14. Does your business have regular and permanently posted business hours? ..... ❒ Yes ❒ No

Business days and hours of operation: Days: _____ Hours: _____

Does your business have permanently attached signage that identifies the name of the business as stated on this application? ..... ❒ Yes ❒ No

15. Do you own the building in which your business is located? ..... ❒ Yes ❒ No

Do you lease the building in which your business is located? ..... ❒ Yes ❒ No

(If you answered yes, attach a copy of the written lease agreement to the application.)

If anyone other than you holds an ownership interest in the building, provide the following information about that person(s): (Use additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

16. Do you have the administrative and fiscal foundation to enable your business to survive as a going concern? ..... ❒ Yes ❒ No

17. 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.

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

Address (number, street)	City	State	Nine-digit ZIP code

Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	Nine-digit ZIP code

18. Do you have the necessary equipment, office supplies, and facilities available to carry out your business, including storing and retrieving such records as are necessary to fully disclose the type and extent of services provided to Medi-Cal beneficiaries? (See Title 22, CCR, Section 51476.) ..... ❒ Yes ❒ No

19. Does your business involve the trade, sale, rental, or transfer of upholstered-furniture (including wheelchairs) or bedding? ..... ❒ Yes ❒ No

If yes, provide your Home Medical Device Retailer license number _____, or your retail furniture and bedding dealer's license or retail furniture dealer's license number _____.

20. Does your business involve the trade, sale, rental, or transfer of medical devices or durable medical equipment/devices for use in the home to treat acute or chronic illness or injuries? ..... ❒ Yes ❒ No

If yes, provide your Home Medical Device Retailer license number _____.

21. Does your business involve the trade, sale, rental, or transfer of dangerous or legend drugs and/or dangerous or legend medical equipment/devices? ..... ❒ Yes ❒ No

If yes, provide your Home Medical Device Retailer Exemptee license number _____.

22. Does the applicant provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? ..... ❒ Yes ❒ No

If yes, does the applicant have on staff, either as an employee or independent contractor, or does the applicant 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

23. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give the percentage of each business activity in which the applicant or provider engages. Total the percentages at the end of this question. Percentages must total 100 percent. (See instructions for computing percentages.)

A. ❒ Beds _____%

B. ❒ Wheelchairs _____%

C. ❒ Ostomy supplies (describe): _____ _____%

D. ❒ Oxygen/oxygen therapy equipment and supplies _____%

(describe): _____

E. ❒ Urinary catheters, bags, etc. (describe): _____ _____%

F. ❒ Incontinence medical supplies (describe): _____ _____%

You must comply with Article 3.7 of the Welfare and Institutions Code. If you are not selling incontinence supplies, enter zero (0) in the percentage column.

G. ❒ Infusion equipment and supplies (describe): _____ _____%

H. ❒ Other (describe): _____ _____%

TOTAL _____%

24. **Proof of Liability Insurance—Applicant must attach a copy of their certificate of insurance for the business address.**

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy) / /	Expiration date of policy (mm/dd/yyyy) / /

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number ( )	Fax number ( )	E-mail address

25. Does the applicant have Worker's Compensation insurance as required by state law? ❒ Yes ❒ No ❒ N/A

If applicable, attach proof of maintenance of Worker's Compensation insurance. If not applicable, check N/A and provide an explanation:

Information About Individual Signing This Application

26. Printed name of provider (last) (first) (middle)

27. Gender ❒ Male ❒ Female

28. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

29. Date of birth / /

30. Social security number (***Optional***—see Privacy Statement below.) ___ ___ ___ — ___ ___ — ___ ___ ___ ___

31. 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.

Signature of provider	Title

Executed at: _____, _____ on _____ / /
(City) (State) (Date)

32. Notary Public — Please see instructions under number 32 for who must have their application 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 the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). 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. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal 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, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division, (916) 323-1945.