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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Dear Applicant:

Thank you for your recent request for the *Medi-Cal Ordering/Referring/Prescribing Provider Application/Agreement/Disclosure Statement for Physician and Non-Physician Practitioners* (DHCS 6219, rev. 05/15). Please complete the attached form and return it to:

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

Please read all the instructions included in the DHCS 6219 application form carefully and complete each item. Incomplete forms will be returned.

PLEASE NOTE: If you are an individual currently enrolled as a rendering or billing provider with your Type 1 National Provider Identifier (NPI) in Medicare or the Medi-Cal program, you should **not** complete this form. This form can only be used for the enrollment of an ordering/referring/prescribing-only provider.

Applicants and providers are required to submit their Type 1 NPI with the DHCS 6219 application form. Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for their Type 1 NPI listed in the application, along with the other required attachments.

It is your responsibility to report to the Department of Health Care Services (DHCS) any modifications to information previously submitted within 35 days from the date of the change. Changes may be reported on the DHCS 6219 application form or on the *Medi-Cal Supplemental Changes* (DHCS 6209, rev. 01/13) form.

If you have any enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or mail your question(s) to the DHCS Provider Enrollment Division at the address above or via email at PEDCorr@dhcs.ca.gov.

If you wish to be reimbursed for services performed, you must submit a full application package as required by the Medi-Cal program. Enrollment forms are available on the DHCS website at *www.dhcs.ca.gov*.

Provider Enrollment Division

Attachments (Rev. 05/15)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL ORDERING/REFERRING/PRESCRIBING PROVIDER APPLICATION /AGREEMENT/ DISCLOSURE STATEMENT FOR PHYSICIAN AND NON-PHYCISIAN PRACTITIONERS

This application is for the sole purpose of ordering/referring/prescribing items and services to Medi-Cal beneficiaries.

This type of enrollment does not allow the Medi-Cal program to reimburse the applicant/provider for services provided. If applicant/provider wishes to be reimbursed for services performed, he/she must submit a full application package as required by the Medi-Cal program.

***** If you are an individual currently enrolled in Medicare or the Medi-Cal program with your Type1 NPI, you do NOT need to complete this 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 or 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 part of an application for enrollment or continued enrollment (California Code of Regulations, Title 22, Section 51000.55) solely as an ordering/referring/prescribing provider in the Medi-Cal program. Applicant/Provider must also provide additional information and documentation. Applicant/Providers may be subject to an onsite inspection and to unannounced visits prior to enrollment or approval of continued enrollment in a program. Additional information can be found on the following Medi-Cal Website (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

Omission of any information on this form, or the failure to provide required documentation or signature in ink on any of these documents may result in denial of the application as provided in California Code of Regulations (CCR). Title 22, Section 51000.50.

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

National Provider Identifier – enter your NPI. For ordering/referring/prescribing individuals, a Type 1 NPI is required.
Enter the date you are completing the application.

"Enrollment Action Requested" – mark the appropriate box.

Provider type – mark the appropriate box for provider type.

I. Identifying Information
   1. "Legal Name" – enter the applicant's/provider's legal name (last, first and middle) as it appears on the professional license.
   2. "Date of Birth" – enter the date of birth of the applicant/provider.
   3. "Gender" – enter the gender of the applicant/provider.
   4. "Mailing address" – enter the address where correspondence may be sent to the applicant/provider directly. This address **cannot** be a billing agency's address or a P.O. Box.
   5. "Social Security number" – enter the social security number of the applicant/provider (This field is ***mandatory*** – see Privacy Statement on page 5).
   6. Enter the driver's license or state-issued identification number and state of issuance of the applicant/provider. 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.
   7. Enter the professional license, certificate number, or other permit or approval to provide health care, of the applicant/provider. Attach a legible copy of the license, certificate, permit or approval. Enter the **effective date** and **expiration date** of the license, certificate, permit or approval. List specialty(ies), if applicable.
   8. "Business address(es)" – enter the business location including the street name and number, room or suite number or letter, city, county, state and nine-digit ZIP code where services are provided. A post office box or commercial box is not acceptable. List all locations. Attach additional sheets if necessary.

9. "Name of entity(ies) at which services are being rendered" – enter the name of the Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Critical Access Hospital (CAH), Primary Care Clinics or if employed by the Department of Veterans Affairs, Public Health Services, Department of Defense Tricare and IHS or Tribal Organization or other entity at which the applicant/provider provides services. Please indicate if the applicant/provider is a licensed resident or fellow. If not employed in any of the foregoing, please provide an explanation why applicant/provider is enrolling solely as an ordering/referring/prescribing provider.

II. Disclosure information
1. Check the appropriate box and provide the date of conviction if applicable.
2. Check the appropriate box and provide the date of the final judgment if applicable.
3. Check the appropriate box and provide the date of settlement if applicable.
4. Check the appropriate box and list all provider numbers, if applicable, as well as the state(s) and name(s) applicant or provider used when participating in another state Medicaid program. If you cannot provide the numbers, please explain.
5. Check the appropriate box and list all provider numbers, if applicable, provide the effective date(s) of suspension(s), dates(s) of reinstatement, and Medi-Cal, Medicare and/or Medicaid NPIs or provider number(s). Attach verification of reinstatement to the applicable program.
6. Check the appropriate box and, if applicable, list the state(s) where applicant's or provider's license, certificate or other approval to provide health care was suspended or revoked, the action taken, and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
7. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending, the action taken, and the effective dates of those actions. Attach a written confirmation from the licensing authority that professional privileges have been restored.
8. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was disciplined by any licensing authority, and the effective dates of those actions. Attach a written confirmation of the licensing authority decision(s) including any terms and conditions for each decision.
9. List below fines/debts due and owing by applicant or provider to any federal, state, or local government that relate to Medicare, Medicaid, and all other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligations(s). Submit copies of all documents pertaining to the arrangement(s) including terms and conditions. If not applicable, Check N/A box.

III. Provider Agreement

Print name of the applicant/provider signing the application. An original signature of the applicant/provider is required. Include the city, state, and the date where and when the application was signed. Include the applicant's/provider's e-mail address and contact phone number.

Contact Person's Information:

To assist in the timely processing of the application package, enter the name, email address and telephone number or cellular phone number of the individual who can be contacted by Provider Enrollment staff to answer questions regarding the application package. Failure to include this information may result in the application package being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

Remember to attach a legible copy of the following:

- ☐ Driver's license or state-issued identification card
- ☐ Professional License Certificate (Pocket License)
- ☐ National Provider Identifier verification (CMS/NPPES confirmation)

Please attach the additional requirements, if applicable:

- ☐ Drug Enforcement Agency (DEA) certificate
- ☐ Anesthesia Permit
- ☐ Conscious Sedation Permit
- ☐ Verification of reinstatement
- ☐ Written confirmation from licensing authority that your professional privileges have been restored.
- ☐ Written confirmation from the licensing authority that includes the terms and conditions of the disciplinary action taken and the status of the licensure.
- ☐ Copies of payment arrangement documents
- ☐ Notary Public Certificate of acknowledgment

Medi-Cal Ordering/Referring/Prescribing Provider Application/ Agreement/Disclosure Statement For Physician and Non-physician Practitioners

***** If you are an individual currently enrolled in Medicare or the Medi-Cal program with your Type1 NPI, you do NOT need to complete this form. *****

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.

- 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 Denti-Cal return completed forms to:
  Department of Health Care Services
  Medi-Cal Dental Program (Denti-Cal)
  Provider Enrollment
  P.O. Box 15609
  Sacramento, CA 95852-0609
  (800) 423-0507

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.

FOR STATE USE ONLY

National Provider Identifier (NPI):	**Date** / /

ENROLLMENT ACTION REQUESTED

☐ I am enrolling for the sole purpose of ordering/referring/prescribing
☐ I am enrolled for the sole purpose of ordering/referring/prescribing and I am updating my information

PROVIDER TYPE (check one)

☐ Audiologist	☐Certified Registered Nurse Anesthetist	☐Optometrist	☐Psychologist
☐ Certified Nurse Midwife	☐Dentist	☐Physician/Osteopathic Physician	☐Other: _____
☐ Chiropractor	☐Nurse Practitioner	☐Physician Assistant	
☐ Clinical Social Worker		☐Podiatrist	

I. IDENTIFYING INFORMATION

1. Legal Name of Applicant/Provider (as it appears on professional license) *(LAST) (FIRST) (MIDDLE)*	2. Date of birth / /	3. Gender

4. Mailing address of the applicant/provider (number, street). Cannot be a billing agency's address or a P.O. Box.	City	State	Nine-digit ZIP Code

5. Social security number (required)	6. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

7. Professional license/certificate permit number (attach legible copy)	License Effective Date / /	License Expiration Date / /	List Specialty(ies) (if applicable)

8. Business Address(es) at which services are provided (number, street). Attach additional pages if necessary	City	State	Nine-digit ZIP Code

9. Name of entity(ies) at which services are being provided.(Attach additional pages if necessary)

II. DISCLOSURE INFORMATION

Respond to the following questions

1. Within ten years of the date of this statement, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐Yes ☐No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____/____/_____

2. Within ten years of the date of this statement, have you, the applicant/provider, been found liable for fraud abuse involving a government program in any civil proceeding? ☐Yes ☐No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____/____/_____

3. Within ten years of the date of this statement, have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐Yes ☐No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____/____/_____

4. Do you, the applicant/provider, currently participate or have you ***ever*** participated as a provider in the Medi-Cal program or in any other State's Medicaid program? ☐Yes ☐No

If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	NPI AND/OR PROVIDER NUMBER(S)

5. Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medi-Cal, or another State's Medicaid program? ☐Yes ☐No

If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	NPI AND/OR PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal		/ /	/ /
☐ Medicaid		/ /	/ /
☐ Medicare		/ /	/ /
☐ Medi-Cal		/ /	/ /
☐ Medicaid		/ /	/ /
☐ Medicare		/ /	/ /

6. Has the individual license, certificate or other approval to provide health care of the applicant/provider ***ever*** been suspended or revoked? ☐Yes ☐No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

7. Have you, the applicant/provider, ***ever*** lost or surrendered your license, certificate or other approval to provide health care while a disciplinary hearing was pending? ☐Yes ☐No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

8. Has the license, certificate or other approval to provide health care of the applicant/provider ***ever*** been disciplined by any licensing authority? ☐Yes ☐No

If yes, attach a copy of the written confirmation from the licensing authority decision(s) including any terms and conditions for each decision and provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

9. List below fines/debts due and owing by applicant/provider to any federal, state or local government that relate to Medicare, Medicaid and all other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). Submit copies of all documents pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐N/A

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
		/ /	/ /
		/ /	/ /

III. PROVIDER AGREEMENT

I understand that in the future, if I wish to be reimbursed by Medi-Cal for the services performed, I must first submit a full application package as required by the Medi-Cal program.

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments is true, accurate and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to Title 22, California Code of Regulations, Sections 51000.30(a)(2)(B).

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider number used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Care Services ("DHCS"), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and Medi-Cal program policies and procedures as published in the Medi-Cal provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider with the Medi-Cal program.

I also agree that DHCS and/or AG may make unannounced visits to Applicant/Provider, at any of the Applicant's/Provider's business locations, before, during and after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

I certify that I am an individual practitioner who is applying for the sole purpose of ordering, referring or prescribing items or services to Medi-Cal beneficiaries. I understand that this enrollment type does <u>not</u> allow the Medi-Cal program to reimburse me for services provided.

Printed legal name of applicant/provider (Last) (First) (Middle)

E-mail address	Telephone Number

Applicant's/Provider's Original Signature (in ink)

(City) (State) (Date)

Executed at: _____ , _____ on _____

Notary Public:
Applicants/providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Act **ARE NOT REQUIRED** to have this form notarized. If notarization is required, 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:

☐ Check here if you are the same person identified in Item 1 of this section.

Contact person's name

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 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 Denti-Cal at (800) 423-0507.