DEPARTMENT OF HEALTH SERVICES
714 / 744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-0499

April 27, 2001

N.L.: 06-0301 **CORRECTED**
Index: Provider Enrollment

TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS AND MEDICAL CONSULTANTS AND CHIEF THERAPISTS AND STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF

SUBJECT: REVISION OF CCS/GENETICALLY HANDICAPPED PERSONS PROGRAM PANEL APPLICATIONS

The CMS Branch is pleased to announce revisions of the applications for providers wishing to participate in the CCS Program. The CMS Branch has incorporated the CCS paneling application with the application for a CGP billing number that is issued to allow for claims payment through the Department's Fiscal Intermediary. The applications include:

1. **Individual Health Care Professional Paneling Application (see Enclosure A)**

   This application is to be completed by individual health care professionals who are required to be paneled in order to participate in the CCS program. This document also allows the provider to be assigned a CGP billing number.

2. **Individual Non-Panel Provider Application (see Enclosure B)**

   This application is to be completed by individual health care professionals or providers for whom CCS paneling is not required, but who wish to bill the CCS program for authorized services. This document also allows the provider to be assigned a CGP billing number.

3. **CCS/GHPP Group Provider Application (see Enclosure C)**

   This application is to be completed by a professional group which include physician or dental members of the group who want to participate in and bill the CCS program for authorized services. This application is to be completed when the group is billing for services on behalf of one or more of its member (rendering) providers. Provider members of the group that require CCS paneling must also complete the Individual Health Care Professional Paneling Application and the group must submit it with the

Group Provider Application. This is necessary even if the provider is already 'paneled', in that a unique CGP number must be assigned for each place of service at which the provider is delivering health care.

Each member of the group that wishes to participate in the CCS program and does not require CCS paneling for participation must complete the Individual Non-Panel Application in order to receive a CGP number. This application must also be submitted with the Group Provider Application.

Additionally, a **Change of Request for Individual Health Care Professionals or Group Provider** form (see Enclosure D) has been developed. This form is available for providers and groups requesting changes to the existing CCS panel file or to the CGP provider file. The form also allows providers to request reactivation of a CGP provider number or a change of service delivery address.

Effective the date of this notice, the enclosed applications are to be used. Complete instructions and provider participation requirements are included with each application. The enclosed applications and change of information forms may be photocopied.

Each individual provider or group must submit the completed application with original signatures to:

Children's Medical Services Branch
Provider Services Unit
Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320

Electronic copies of these forms can be requested by e-mail from Mary Kay Hill, Analyst, Provider Services Unit at mhilll@dhs.ca.gov.

If you have any questions regarding the use of these new applications, please contact Mrs. Hill at (916) 322-8793 or send her an e-mail message.

Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch

Enclosures

California Children Services and Genetically Handicapped Persons Programs
INDIVIDUAL HEALTH CARE PROFESSIONAL PANELING APPLICATION

Return Completed Form To:
Department of Health Services
Children's Medical Services Branch, Provider Services Unit
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 322-8702

IMPORTANT:
- **Refer to Attached Instructions to Complete this Form**
- **Type or Print Legibly**

Paneling Requested for (CHECK ONE):
- ❑ California Children's Services (CCS) Program
- ❑ Genetically Handicapped Persons Program (GHPP)
- ❑ CCS Program and GHPP

FOR CCS/GHPP CASE MANAGEMENT USE ONLY:
❑ Authorization for emergency care; Provider not currently paneled.
Effective Date of Authorization: _____
Authorized By: _____
Program Office: _____
Date: _____

Provider Type: (CHECK ONE):

❑ Physician	❑ Audiologist	❑ Optometrist	❑ Registered Nurse
❑ Oral Surgeon	❑ Dietitian/Nutritionist	❑ Orthotist	❑ Social Worker
❑ Orthodontist	❑ Genetic Counselor	❑ Physical Therapist	❑ Prosthetist
❑ Podiatrist	❑ Occupational Therapist	❑ Psychologist	❑ Speech-Language Pathologist

1. Legal Name of Applicant: _____
(Last Name, Title, First Name, Middle Initial)

2. Social Security Number: (REQUIRED IF NOT USING FEDERAL TAX ID NUMBER -ATTACH COPY) _____

3. Gender: ❑ Male ❑ Female

4. Business Address (Office/Hospital) (See Instruction "Note"): _____
(Street, City, County, State, Zip Code)

5. Business Telephone Number:

6. Fax Number:

7. E-mail Address:

8. Pay-To Name: _____
(Last, Title, First, Middle Initial)

9. Is the Pay-To Name a DBA name? ☐ Yes ☐ No

10. Federal Tax Identification Number: (ATTACH COPY) _____

11. Pay-To Address: _____
(Street, City, State, Zip Code)

12. Active Medi-Cal Provider Number(s):

13. Professional License, Registration or Certification Number: (ATTACH COPY)

14. Effective Date:

15. Expiration Date:

16. Type of Medical or Dental Practice (CHECK ONE):
☐ Solo Practice ☐ Dental School/Clinic
☐ Group (Specify Name of Group): _____

17. Type of Business (CHECK ONE):
☐ Sole Practitioner ☐ Corporation
☐ Partnership

18. ☐ Yes ☐ No Are you a member of a health care team providing multidisciplinary, multispecialty services in a hospital or outpatient department/clinic to children with CCS-eligible medical conditions or to children and adults who have GHPP-eligible medical conditions? If yes, provide the following information: _____
(Name of Hospital, City, State, Name of Specialty Clinic)

19. Qualifying Professional and Post-Graduate Education:

Medical/Professional School	State	Country	Degree Received	Graduation Date

20. Specialty: _____ Subspecialty: _____

For State Use Only

Reviewed By: _____ Entered By: _____ Date: _____

21. Post-Graduate Training and Experience:

	Name of Institution	State and Country	Type of Training	Specialty	From/To Dates
Internship			Internship		
Residencies, Fellowships, Preceptorships, and Teaching Appointments (indicate clinical or academic)					

22. Board Certificate: (ATTACH COPY)

Name of Issuing Board	Specialty/Sub-specialty	Certificate Number	Date Certified	Expiration Date

23. If not Board certified, specify your status:

- ❑ Eligible to take exam. Attach verification letter from Board. Date you plan to take exam: _____
- ❑ Other (explain): _____

24. Employment History (BEGIN WITH MOST RECENT JOB):

Start Date:	End Date:	Job Title/Classification:
Hours Per Week:	Total Worked (Years/Months):	Name of Hospital/Business, including City and State:
Duties Performed:		
Start Date:	End Date:	Job Title/Classification:
Hours Per Week:	Total Worked (Years/Months):	Name of Hospital/Business, including City and State:
Duties Performed:		
Start Date:	End Date:	Job Title/Classification:
Hours Per Week:	Total Worked (Years/Months):	Name of Hospital/Business, including City and State:
Duties Performed:		

Applicant Name:	Date:

I agree to:

a. Request prior authorization for services from CCS/GHPP.
b. Abide by the laws, regulations, and policies of CCS/GHPP and Medi-Cal programs.
c. Provide care to Medi-Cal patients whose services are authorized by CCS/GHPP and bill Medi-Cal for those services.
d. Submit timely reports of services rendered.
e. Bill insurance first, and Medi-Cal and Medicare, if eligible, within six months of the month of service.
f. Bill CCS/GHPP within six months of the month of service, receipt of insurance payment, or notice of insurance rejection. Bill CCS/GHPP within 12 months of date of service if insurance fails to respond.
g. Accept payment in accordance with state regulations as payment in full; not bill families in whole or in part for any CCS/GHPP covered benefit; not question families regarding their ability to pay for CCS/GHPP covered services.
h. Serve CCS/GHPP clients regardless of race, color, religion, national origin, or ancestry.

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 Name Middle Initial Last Name Date

Privacy Statement

(As Required By Civil Code Section 1798 et seq.)

All information requested by the application 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 Services by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of paneling as a CCS/GHPP provider and issuance of the CGP provider number to obtain reimbursement from the CCS/GHPP programs. 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 CCS/GHPP programs. 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 Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

Did you remember to enclose (as applicable):

- ❑ Copy of Social Security Card
- ❑ Copy of Federal Tax Identification number verification
- ❑ Copy of Professional license, registration, certification or other approval
- ❑ Copy of Curriculum Vitae
- ❑ Copy of Board certificate, and if applicable, the sub-specialty Board certificate
- ❑ Board eligibility verification letter
- ❑ Letter signed by social worker applicant's supervisor or social work department director

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HEALTH CARE PROFESSIONAL PANELING APPLICATION

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

Individual health care professionals who require paneling by the CCS/GHPP programs (See **Provider Types** below) must complete this application in order to provide authorized services to CCS/GHPP clients and bill the CCS/GHPP programs. This application must also be completed when the individual health care professional is a rendering provider of a group provider.

Upon review and approval of this application, the applicant will be paneled and assigned CCS/GHPP provider number(s) for billing purposes. Omission of any information or documentation on this application or the failure to sign this application may result in delays in or inability to process this application. Applicants may be contacted in writing if additional information and documentation is needed.

Paneling Requested for means the program for which participation is sought.

Check the box for the CCS program if you wish to become a paneled provider in the CCS program in order to provide authorized services to CCS clients and to bill the CCS program. The CCS program authorizes diagnostic and treatment services for children from birth to age 21 years who have CCS-eligible or potentially eligible medical conditions specified in Title 22, CCR, commencing with Section 41800.

Check the box for GHPP if you wish to become a paneled provider in the GHPP in order to provide authorized services to GHPP clients and to bill GHPP. The GHPP authorizes services to children and adults who have GHPP-eligible medical conditions specified in Title 17, CCR, Section 2932.

Check the box for CCS Program and GHPP if you wish to become a paneled provider and bill for services under both programs.

Provider Type: The professionals listed on this application require paneling by the CCS/GHPP programs. Check the appropriate box that describes the profession for which you are applying to be paneled by the CCS/GHPP programs. A separate application must be completed if you wish to be paneled under more than one profession.

1. Legal Name of Applicant means the name under which the applicant is applying for paneling by the CCS/GHPP programs.

2. Provide the Social Security Number of the individual named in number 1. The Social Security Number is not required if the applicant is using their Federal Tax Identification Number requested in item number 10. Attach a clearly legible copy of the Social Security card if this number is being provided.

3. Check the appropriate box for the gender of the applicant.

4. Business Address (OFFICE/HOSPITAL) means the office or hospital location where the applicant renders 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. **Note**: Applicants with multiple business addresses, except dental specialist applicants, must complete a separate application for each business address. Applicants who are dental specialists with multiple business addresses must attach a separate sheet to this application listing each business address, and the information requested in numbers 4 through 11.

5. Business Telephone Number means the primary business telephone number used at the applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the Business Telephone Number.

6. Fax Number means the facsimile number used at the business address.

7. E-mail address means the address to which electronic communications may be sent.

8. Pay-To Name means the name of the person or business in which payment should be issued by the CCS/GHPP programs for authorized services rendered by the individual named in number 1. The Pay-To Name may be the legal name indicated in number 1, or another person or business chosen by the applicant. **Note**: See number 9.

9. Indicate Yes or No if the Pay-To Name is a Doing Business As (DBA) name. If Yes, the DBA name will be the name in which payment will be issued by the CCS/GHPP programs.

10. Provide the Federal Tax Identification Number of the Pay-To Name indicated in number 8 as issued by the Internal Revenue Service (IRS). **Note**: If "Yes" is indicated in number 9, the Federal Tax Identification Number must be the number assigned by the IRS to the DBA Name. Attach a clearly legible copy of the Federal Tax Identification verification to the application.

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HEALTH CARE PROFESSIONAL PANELING APPLICATION CONTINUED

11. The Pay-To address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit zip code. Each Pay-To Address must be associated to the Business Address as required in number 4.

12. Provide all active Medi-Cal Provider Number(s) of the applicant if the applicant is enrolled in the Medi-Cal program. Provide only the active Medi-Cal provider number(s) that is assigned to the Provider Type indicated on this form.

13. Provide the applicant's professional license, registration, certification number, or other approval to provide health care services. Attach a clearly legible copy to the application.

14. Indicate the effective date of the professional license, registration, certification number, or other approval indicated in number 13.

15. Indicate the expiration date of the professional license, registration, certification number, or other approval indicated in number 13.

16. Type of Medical or Dental Practice must be completed only by applicants who are physicians or dentists. Indicate whether the applicant is in a solo practice, is in a dental school or clinic, or is a member of a group. If the applicant is in a group practice, indicate the name of the group.

17. Indicate the Type of Business that applies to your business structure.

18. Indicate Yes or No if the applicant is working in a hospital outpatient department or clinic providing multidisciplinary, multispecialty health care services to children with CCS-eligible medical conditions or to children and adults who have GHPP-eligible medical conditions. If yes, indicate the name, city and state of the hospital, and the name of the specialty clinic in which the applicant works.

19. Provide the educational background of the applicant. Refer to the end of these instructions for the educational requirements appropriate to the applicant's Provider Type. Indicate the name of the medical/professional school, the state, country, degree received, and the graduation date for each educational entry. In lieu of completing this section of the form, the applicant's Curriculum Vitae (CV) may be attached as long as the CV contains the required information.

20. Specialty and Subspecialty must be completed only by applicant's who are applying who are physicians or dentists. Provide the area of expertise of your medical or dental practice.

21. Provide the Post-Graduate Training and Experience of the applicant. Indicate the name of the institution, state, country, type of training, specialty, and from/to dates.

22. Board Certification must be completed only by applicants who are applying to become CCS/GHPP paneled physicians. Provide the name of the issuing board, specialty, certificate number, date certified, and expiration date, if applicable. Attach a clearly legible copy of the certificate, and if applicable, the sub-specialty Board certificate, to the application.

23. Complete this item only if the applicant is a physician and is not Board Certified, as indicated in number 22.

24. Provide the Employment History of the applicant. Refer to the end of these instructions for the employment requirements appropriate to the applicant's Provider Type. Indicate the start and end dates, job title/classification, hours per week, total years/months worked, name of employer (hospital/business) and city and state. Begin with the most recent job. In lieu of completing this section of the form, the applicant's Curriculum Vitae (CV) may be attached as long as the CV contains the required information.

- Type or legibly print the applicant name and date at the top of page 3.

- 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/GHPP Program Participation Requirements
By Provider Type

Physicians: (a) **Physicians** providing medical services to CCS/GHPP applicants or clients must be (1) licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California and (2) certified by a member board of the American Board of Medical Specialties. Physicians who are not board certified but who are eligible by training for the certifying examination may participate in the CCS program for not more than three years. (b) **Family Practice Physicians** must meet the requirements of (a) and have documented experience treating children with CCS-eligible medical conditions for at least five years, or have treated 100 or more such children.

Oral Surgeons: Oral Surgeons must be licensed to practice dentistry by the California Board of Dental Examiners, confine their practice to the specialty of oral surgery and be certified in oral and maxillofacial surgery by a specialty board recognized by the Commission on Dental Accreditation of the American Dental Association or have successfully completed a course of advanced study in oral surgery of three years or more in programs recognized by the Council on Dental Education of the American Dental Association.

Orthodontists: Orthodontists must be licensed to practice dentistry by the California Board of Dental Examiners, confine their practice to the specialty of orthodontics and (a) have successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association, or (b) have completed advanced training in orthodontics prior to July 1, 1969 and be a member of, or eligible for, membership in the American Association of Orthodontists.

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

Audiologists: Audiologists must be licensed as such by the California Speech-Language Pathology and Audiology Board and have two years of clinical experience providing audiology services, one of which must have been with infants, children and adolescents. The experience may include the clinical fellowship year.

Genetic Counselors: Genetic Counselors must be certified by the American Board of Genetics Counseling and have at least one year of experience providing genetic counseling.

Dietitians/Nutritionists: Dietitians/Nutritionists must be registered by the Commission on Dietetic Registration of the American Dietetic Association, have at least two years or equivalent of fulltime clinical nutrition/diet therapy experience as part of a multidisciplinary team providing nutrition assessment and counseling for acute or chronically ill patients. Dietitians/Nutritionists applying to participate in the CCS program must have one of the required years of clinical experience providing services to infants, children and adolescents with CCS-eligible medical conditions. Dietitians/Nutritionists applying to participate in GHPP must have one of the required years of clinical experience providing services to adults who have GHPP-eligible medical conditions. Dietitians/Nutritionists whose qualifying experience is with infants, children and adolescents with CCS-eligible medical conditions must have also completed a competency-based program on nutrition assessment and diet counseling for children with CCS-eligible medical conditions. For purposes of this application, competency-based program means a course, fellowship program, or practicum in which specific objectives are defined for each of the separate skills taught in a training program with integrated didactic and practical instruction and successful completion of an examination demonstrating mastery of each skill.

Occupational Therapists (OT): OTs must be graduates of an occupational therapy curriculum that is accredited by the American Occupational Therapy Association, the World Federation of Occupational Therapy, or another nationally recognized accrediting agency, be certified by the National Board for Certification in Occupational Therapy, and have at least one year of experience, beyond internship, providing occupational therapy to infants, children and adolescents who have CCS-eligible medical conditions. Internship means the fieldwork performed following completion of curriculum.

Orthotists: Orthotists must be certified by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

Optometrists: Optometrists must be licensed as such by the California State Board of Optometry and have documentation of experience in the care of children commensurate with services covered by the CCS/GHPP programs.

Physical Therapists: Physical therapists must be licensed as such by the Physical Therapy Board of California and must have one year of experience, beyond internship, providing physical therapy to infants, children and adolescents with CCS-eligible medical conditions. Internship means the fieldwork performed following completion of curriculum.

Prosthetists: Prosthetists must be certified by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

CCS/GHPP Program Participation Requirements
By Provider Type,
Continued

Psychologists: Psychologists must be licensed as such by the California Board of Psychology or credentialed by the California State Board of Education or Commission on Teacher Credentialing, and have a minimum of two years of clinical experience in which at least 50 percent of the individual's time has been spent counseling or testing children who have mental disorders, developmental disabilities, or CCS-eligible medical conditions.

Registered Nurses: Registered Nurses must be licensed as such by the California Board of Registered Nursing, be a designated core member of an outpatient clinic's multidisciplinary, multispecialty team providing care to children with CCS-eligible medical conditions or adults with GHPP-eligible medical conditions, and must have:
(1) A minimum preparation of a baccalaureate degree in nursing from a program having requirements equal to or greater than a baccalaureate level nursing program approved by the California Board of Registered Nursing;
(2) A minimum of two years of clinical nursing experience of which one year must be in pediatrics, unless the outpatient clinic had a separate adult program only, in which case the pediatric requirement may be waived; and
(3) Responsibilities in an outpatient clinic that include, but are not limited to, nursing assessment and intervention; coordination of patient's care between hospitalizations, outpatient services, and community agencies; participation in team conferences, quality improvement programs, and in-service programs.

Social Workers:
(a) Social Workers must be licensed as a clinical social worker by the California Board of Behavioral Science Examiners or have a master's degree in social work from a school accredited by the Council on Social Work Education and have at least 7,500 hours or five years' fulltime social work experience.
(b) Individuals who do not meet the requirements of (a) may be CCS paneled by writing a letter containing evidence of both of the following:
(1) That supervision received will be provided by a social worker who meets the requirements of (a); and
(2) That the level of supervision received will be a minimum of weekly supervision for applicant's with less than two year's of experience, or a minimum of monthly supervision for applicant's with more than two year' of experience. The letter must be signed by the applicant's supervisor or social work department director and attached to this application.

Speech-Language Pathologists: Speech-language pathologists must be licensed as such by the California Speech-Language Pathology and Audiology Board and have two years of clinical experience providing speech-language pathology services, one year of which must have been with infants, children and adolescents with CCS-eligible medical conditions. The required experience may include the clinical fellowship year.

California Children's Services and Genetically Handicapped Persons Program
INDIVIDUAL NON-PANELED PROVIDER APPLICATION

IMPORTANT:
- **Refer to Attached Instructions to Complete this Form**
- **Type or Print Legibly**

Return Completed Form To:
Department of Health Services
Children's Medical Services Branch, Provider Services Unit
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 322-8702

Provider Number Requested for (CHECK ONE):
- ❑ California Children's Services (CCS) Program
- ❑ Genetically Handicapped Persons Program (GHPP)
- ❑ CCS Program and GHPP

FOR CCS/GHPP CASE MANAGEMENT USE ONLY:

☐ Authorization for emergency care; Provider not currently issued a CGP provider number.

Effective Date of Authorization: _____

Authorized By: _____

Program Office: _____

Date: _____

Provider Type: (CHECK ONE):
- ❑ Endodontist
- ❑ General Dentist
- ❑ Pediatric Dentist
- ❑ Periodontist
- ❑ Prosthodontist
- ❑ Durable Medical Equipment
- ❑ Hearing Aid Dispenser
- ❑ Home Health Agency
- ❑ Laboratory
- ❑ Medical Transportation
- ❑ Pharmacy
- ❑ Other (SPECIFY): _____

1. Legal Name of Applicant: _____

2. Social Security Number: (REQUIRED IF NOT USING FEDERAL TAX ID NUMBER - ATTACH COPY) _____

3. Gender:
- ❑ Male
- ❑ Female

4. Business Address (Office/Hospital) (See Instruction "Note"):

_____
Street City County State Zip Code

5. Business Telephone Number: ( ) _____

6. Fax Number: ( ) _____

7. E-mail Address: _____

8. Pay-To Name: _____
Last Title First Middle Initial

9. Is the Pay-To Name a DBA name?
☐ Yes ☐ No

10. Federal Tax Identification Number: (ATTACH COPY) _____

11. Pay-To Address: _____
Street City State Zip Code

12. Active Medi-Cal Provider Number(s):

13. Professional License, Registration, Certification, or Other Approval Number, if applicable: (ATTACH COPY)

14. Effective Date:

15. Expiration Date:

16. Local Business License Number(s) or Permit(s), if applicable: (ATTACH COPY)

17. Effective Date(s):

18. Expiration Date(s):

19. Type of Medical or Dental Practice (CHECK ONE):

☐ Solo Practice ☐ Dental School/Clinic
☐ Group (Specify Name of Group): _____

20. Type of Business (CHECK ONE):

☐ Sole Practitioner ☐ Corporation
☐ Partnership

FOR STATE USE ONLY

Reviewed By: _____ Entered By: _____ Date: _____

21. ☐ Yes ☐ No Are you a member of a health care team providing multidisciplinary, multispecialty services in a hospital or outpatient department/clinic to children with CCS-eligible medical conditions or to children and adults who have GHPP-eligible medical conditions? If yes, provide the following information:

Name of Hospital | City | State | Name of Specialty Clinic

I agree to:

a. Request prior authorization for services from CCS/GHPP.
b. Abide by the laws, regulations, and policies of CCS/GHPP and Medi-Cal.
c. Provide care to Medi-Cal patients whose services are authorized by CCS/GHPP.
d. Submit timely reports of services rendered.
e. Bill insurance first, and Medi-Cal and Medicare, if eligible, within six months of the month of service.
f. Bill CCS/GHPP within six months of the month of service, receipt of insurance payment, or notice of insurance rejection. Bill CCS/GHPP within 12 months of date of service if insurance fails to respond.
g. Accept payment in accordance with state regulations as payment in full; not bill families in whole or in part for any CCS/GHPP covered benefit; not question families regarding their ability to pay for CCS/GHPP covered services.
h. Serve CCS/GHPP clients regardless of race, color, religion, national origin, or ancestry.

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 Name Middle Initial Last Name Date

Privacy Statement

(As Required By Civil Code Section 1798 et seq.)

All information requested by the application 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 Services by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of paneling as a CCS/GHPP provider and issuance of the CGP provider number to obtain reimbursement from the CCS/GHPP programs. 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 CCS/GHPP programs. 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 Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

Did you remember to enclose (as applicable):

- ☐ Copy of Social Security Card
- ☐ Copy of Federal Tax Identification number verification
- ☐ Copy of Professional license, registration, certification or other approval
- ☐ Copy of Local Business Licenses or Permits

INSTRUCTIONS FOR COMPLETION OF THE INDIVIDUAL NON-PANELED PROVIDER APPLICATION

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

Individual providers who do not require paneling by the CCS/GHPP programs (See **Provider Types** listed below) must complete this application in order to receive authorization for services and to bill the CCS/GHPP programs. This application must also be completed when the individual health care professional is a rendering provider of a provider group.

Upon review and approval of this application, the applicant will be assigned a provider number to use when billing the CCS or GHPP programs. Omission of any information or documentation on this application or the failure to sign this application may result in delays in or inability to process this application. Applicants may be contacted in writing if additional information and documentation is needed.

Provider Number Requested means the program for which participation is sought.

Check the box for the CCS program if you are applying for a provider number to bill the CCS program. The CCS program authorizes diagnostic and treatment services for children from birth to age 21 years who have CCS-eligible or potentially eligible medical conditions specified in Title 22, CCR, commencing with Section 41800.

Check the box for GHPP if you are applying for a provider number to bill GHPP. The GHPP authorizes services for children and adults who have GHPP-eligible medical conditions specified in Title 17, CCR, Section 2932.

Check the box for the CCS Program and GHPP if you are applying for provider numbers for both programs in order to bill for authorized services rendered to CCS and GHPP clients.

Provider Type: The list of professionals and businesses shown on the application do not require paneling by the CCS/GHPP programs but must meet certain license, registration, etc., requirements. Refer to the end of these instructions for the specific requirements by Provider Type. Check the appropriate box that describes your profession or business for which you are applying to obtain a provider number in order to bill the CCS/GHPP programs. Check the "Other" box if your Provider Type is not listed. Call the office listed above if assistance is needed in determining your Provider Type. A separate application must be completed if you wish to apply for participation in the CCS/GHPP programs under more than one profession or business.

1. Legal Name of Applicant means the name under which the applicant is applying for a provider number under the CCS/GHPP program(s).

2. Provider the Social Security Number of the individual named in number 1. The Social Security Number is not required if the applicant is using their Federal Tax Identification Number requested in item number 10. Attach a clearly legible copy of the Social Security card if this number is being provided.

3. Check the appropriate box for the gender of the applicant.

4. Business Address (OFFICE/HOSPITAL) means the office or hospital location where the applicant renders 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. **Note**: Applicants with multiple business addresses, except dental providers, must complete a separate application for each business address. Applicants who are dental providers with multiple business addresses must attach a separate sheet to this application listing each business address and the information requested in numbers 4 through 11.

5. Business Telephone Number means the primary business telephone number used at the applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the Business Telephone Number.

6. Fax Number means the facsimile number used at the business address.

7. E-mail address means the address to which electronic communications may be sent.

8. Pay-To Name means the name of the person or business in which payment should be issued by the CCS/GHPP programs for authorized services rendered by the individual named in number 1. The Pay-To Name may be the legal name indicated in number 1, or another person or business chosen by the applicant. **Note**: See number 9.

9. Indicate Yes or No if the Pay-To Name is a Doing Business As (DBA) name. If Yes, the DBA name will be the name in which payment will be issued by the CCS/GHPP programs.

INSTRUCTIONS FOR COMPLETION OF THE INDIVIDUAL NON-PANELED PROVIDER APPLICATION CONTINUED

10. Provide the Federal Tax Identification Number of the Pay-To Name indicated in number 8 as issued by the Internal Revenue Service (IRS). **Note**: If "Yes" is indicated in number 9, the Federal Tax Identification Number must be the number assigned by the IRS to the DBA Name. Attach a clearly legible copy of the Federal tax identification verification to the application.

11. The Pay-To Address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit zip code. Each Pay-To Address must be associated to the Business Address as required in number 4.

12. Provide all active Medi-Cal Provider Number(s) of the applicant if the applicant is enrolled in the Medi-Cal program. Provide only the active Medi-Cal provider number(s) that is assigned to the Provider Type indicated on this form.

13. Provide the applicant's professional license, registration, certification number, or other approval to provide health care services. Attach a clearly legible copy to the application. Refer to the end of these instructions for the license, registration, etc., requirements for participation in the CCS/GHPP programs.

14. Provide the effective date of the professional license, registration, certification number, or other approval indicated in number 13.

15. Provide the expiration date of the professional license, registration, certification number, or other approval indicated in number 13

16. If applicable, provide the local business license number(s) or permit(s) for any city or county or city and county where you conduct your business activities. Attach a clearly legible copy to the application.

17. Provide the effective date(s) of the local business license or permit number(s) indicated in number 16.

18. Provide the expiration date(s) of the local business license or permit number(s) indicated in number 16.

19. Type of Dental Practice must be completed only by applicants who are dentists. Indicate whether the applicant is in a solo practice, is in a dental school or clinic, or is a member of a group. If the applicant is in a group practice, indicate the name of the group.

20. Indicate the Type of Business that applies to your business structure.

21. Indicate Yes or No if the applicant is working in a hospital outpatient department or clinic providing multidisciplinary, multispecialty health care services to children with CCS-eligible medical conditions or to children and adults who have GHPP-eligible medical conditions. If yes, indicate the name, city and state of the hospital, and the name of the specialty clinic in which the applicant works.

- Print the first name, middle initial, and last name of the individual indicated in number 1.
- Signature of Applicant means the first, middle 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/GHPP Participation Requirements
By Non-Paneled Provider Types

Endodontists, General Dentists, Pediatric Dentists, Periodontists and Prosthodontists must be licensed to practice dentistry by the California Board of Dental Examiners and limit his/her practice to the applicable dental specialty.

Durable Medical Equipment providers, also referred to as Assistive Device and Sick Room Supply dealers, must have a local business license or permit for any city or county or city and county where they conduct their business activities. **Note**: Individual orthotists and prosthetists must be paneled by the CCS program in order to provide orthotic and prosthetic devices to children with CCS-eligible medical conditions. Call the telephone number provided above to request the "Individual Health Care Professional Paneling Application".

Hearing Aid Dispensers must be licensed as such by the Medical Board of California pursuant to Chapter 7.5 (commencing with Section 3300) of the Business and Professions Code.

Home Health Agencies must be licensed as such by the California Department of Health Services pursuant to Division 5 (commencing with Section 74600) of Title 22, California Code of Regulations.

Laboratories, also referred to as clinical laboratories, must meet the requirements of Title 22, CCR, Section 51211.2.

Medical Transportation:
(1) Ambulances must be licensed, operated and equipped in accordance with applicable federal, state and local statutes, ordinances and regulations. Attach a clearly legible copy of the license to the application.
(2) Litter vans must meet the requirements of Title 22, CCR, Section 51231.1.
(3) Wheelchair litter vans must meet the requirements of Title 22, CCR, Section 51231.2.
(4) Litter and/or wheelchair vans: attach an extra sheet to this application indicating the Vehicle Identification Number of each vehicle that will be used to transport beneficiaries; make and model of vehicle; year of vehicle; and license plate number of vehicle.
(5) Air Ambulances must have a certificate number issued by the Federal Aviation Administration. Attach a clearly legible copy of the certificate to this application and on your company letterhead include the name and address of where the aircraft is hangared.

Pharmacies must be licensed as such by the California Board of Pharmacy pursuant to Chapter 9 (commencing with Section 4000) of the Business and Professions Code.

Other: Applicants who check this box must be licensed, registered, certified or have other approval to provide health care services.

California Children's Services and Genetically Handicapped Persons Program
CCS/GHPP GROUP PROVIDER APPLICATION

IMPORTANT:
- **Refer to Attached Instructions to Complete this Form**
- **Type or Print Legibly**

Group Provider Number Requested for (CHECK ONE):
- ☐ California Children's Services (CCS) Program
- ☐ Genetically Handicapped Persons Program (GHPP)
- ☐ CCS Program and GHPP

Return Completed Form To:
Department of Health Services
Children's Medical Services Branch
Provider Services Unit
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 322-8702

Provider Type: (CHECK ONE):

☐ Audiology	☐ Optometry	☐ Physician	☐ Prosthetics
☐ Dental	☐ Orthotics	☐ Podiatry	☐ Speech-Language Pathology
☐ Occupational Therapy	☐ Physical Therapy	☐ Psychology	☐ Other (Specify): _____

1. Legal Name of Group Provider: _____

IMPORTANT - If the Group Provider has more than one business address for which CCS/GHPP participation is requested, a separate CCS/GHPP Group Provider Application must be submitted for <u>each</u> Business Address. Also, rendering providers at each business address must submit the appropriate individual health care professional application. <u>There are exceptions for certain dental providers. Please refer to the Instructions for item numbers 2 and 15 for more information.</u>

2. Business Address (Office/Hospital) (See Instruction "Note"):
_____
Street City County State Zip Code

3. Type of Business (CHECK ONE):
☐ Sole Practitioner
☐ Corporation
☐ Partnership

4. Business Telephone Number: ( ) _____

5. Fax Number: ( ) _____

6. E-mail Address: _____

7. Pay-To Name: _____

8. Is the Pay-To Name a DBA name?
☐ Yes ☐ No

9. Federal Tax Identification Number: (ATTACH COPY)

10. Pay-To Address: _____
Street City State Zip Code

11. Active Medi-Cal Group Provider Number(s):	12. Local Business License Number(s) or permit(s): (ATTACH COPY)	13. Effective Date:	14. Expiration Date:

15. List of Rendering Providers (See Instruction "Note") (ATTACH ADDITIONAL SHEET IF NECESSARY AND LABEL AS NUMBER 15):

Name (FIRST, MIDDLE INITIAL, LAST, TITLE)	Specialty	Professional License Number
1.		
2.		
3.		
4.		

FOR STATE USE ONLY

Reviewed By: _____ Entered By: _____ Date: _____

The Group Provider agrees to:

a. Request prior authorization for services from CCS/GHPP.
b. Abide by the laws, regulations, and policies of CCS/GHPP and Medi-Cal.
c. Provide care to Medi-Cal patients whose services are authorized by CCS/GHPP.
d. Submit timely reports of services rendered.
e. Bill insurance first, and Medi-Cal and Medicare, if eligible, within six months of the month of service.
f. Bill CCS/GHPP within six months of the month of service, receipt of insurance payment, or notice of insurance rejection. Bill CCS/GHPP within 12 months of date of service if insurance fails to respond.
g. Accept payment in accordance with state regulations as payment in full; not bill families in whole or in part for any CCS/GHPP covered benefit; not question families regarding their ability to pay for CCS/GHPP covered services.
h. Serve CCS/GHPP clients regardless of race, color, religion, national origin, or ancestry.

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 and Title of the person authorized to bind the applicant and sign this application:

_____ _____
First Name Middle Initial Last Name Title

Signature of the person authorized to bind the applicant in ANY COLOR OTHER THAN BLACK INK:

_____ _____
First Name Middle Initial Last Name Date

Privacy Statement
(As Required By Civil Code Section 1798 et seq.)

All information requested by the application is mandatory. This information is required by the Department of Health Services by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of paneling as a CCS/GHPP provider and issuance of the CGP provider number to obtain reimbursement from the CCS/GHPP programs. Any information provided will be used to verify eligibility to participate as a provider in the CCS/GHPP programs. 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 contact the Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

Did you remember to enclose (as applicable):

- ☐ Copy of Federal Tax Identification Number verification
- ☐ Copy of Business License
- ☐ Copy of Professional license, registration, certification or other approval

INSTRUCTIONS FOR COMPLETING THE CCS/GHPP GROUP PROVIDER APPLICATION

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

Group Providers (See **Provider Types**) must complete this application in order for rendering providers to receive authorization for services and to bill the CCS/GHPP programs as a Group Provider. In addition to the CCS/GHPP Group Provider Application, each rendering provider of the group provider must complete and submit the appropriate individual health care professional application. Refer to number 15 of these instructions for the exceptions to this requirement.

Upon review and approval of this application and other required documents, the applicant will be assigned a group provider number to use when billing the CCS or GHPP programs for authorized services provided by Rendering Providers. Omission of any information or documentation on this application or the failure to sign this application may result in delays in or inability to process this application. Applicants may be contacted in writing if additional information and documentation is needed.

Group Provider Number Requested for means the program for which participation is sought.

Check the box for the CCS program if you are applying for a group provider number to bill the CCS program. The CCS program authorizes diagnostic and treatment services for children from birth to age 21 years who have CCS-eligible or potentially eligible medical conditions specified in Title 22, CCR, commencing with Section 41800.

Check the box for GHPP if you are applying for a group provider number to bill GHPP. The GHPP authorizes services for children and adults who have GHPP-eligible medical conditions specified in Title 17, CCR, Section 2932.

Check the box for the CCS Program and GHPP if you are applying for group provider numbers for both programs in order to bill for authorized services rendered to CCS and GHPP clients.

Provider Type: Check the appropriate box that describes your professional group type for which you are applying to obtain a group provider number in order to receive authorization for services and to bill the CCS/GHPP programs. If your group includes multiple specialties, select the provider type that reflects the primary focus of the group. Check the "Other" box if your Provider Type is not listed. Call the office listed above if assistance is needed in determining your Provider Type. A separate application must be completed if you wish to participate in the CCS/GHPP program under more than one professional group type. Refer to the end of these instructions for the CCS/GHPP participation requirements by profession.

1. Legal Name of Group Provider means the name under which the applicant is applying for a group provider number under the CCS/GHPP program(s).

2. Business Address (OFFICE/HOSPITAL) means the office or hospital location where the group provider renders 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. **Note**: Group Provider applicants, except certain dental group applicants, who have multiple business addresses for which CCS/GHPP participation is requested must submit a separate CCS/GHPP Group Provider Application for each Business Address. Dental Group Provider applicants with multiple business addresses for which CCS/GHPP participation is requested must submit the following information for their Rendering Providers:

   - For Orthodontists and Oral Surgeons, submit a separate CCS/GHPP Group Provider Application for each Business Address.
   - For Endodontists, General Dentists, Pedodontists, Periodontists and Prosthodontists, attach a separate sheet(s) to this application listing the information requested in numbers 2 through 10 and 15 for each business address.

3. Indicate the Type of Business that applies to your business structure.

4. Business Telephone Number means the primary business telephone number used at the group provider's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the Business Telephone Number.

5. Fax Number means the facsimile number used at the business address.

6. E-mail address means the address to which electronic communications may be sent.

7. Pay-To Name means the name of the person or business in which payment should be issued by the CCS/GHPP programs for authorized services rendered by the rendering providers named in number 15. The Pay-To Name may be the legal name indicated in number 1, or another person or business chosen by the group provider. **Note**: See number 8.

INSTRUCTIONS FOR COMPLETING THE CCS/GHPP GROUP PROVIDER APPLICATION CONTINUED

8. Indicate Yes or No if the Pay-To Name is a Doing Business As (DBA) name. If Yes, the DBA name will be the name in which payment will be issued by the CCS/GHPP programs.

9. Provide the Federal Tax Identification Number of the Pay-To Name indicated in number 7 as issued by the Internal Revenue Service (IRS). **Note**: If "Yes" is indicated in number 8, the Federal Tax Identification Number must be the number assigned by the IRS to the DBA Name. Attach a clearly legible copy of the Federal tax identification verification to the application.

10. The Pay-To address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit zip code.

11. Provide all active Medi-Cal Group Provider Numbers of the group provider if the group provider is enrolled in the Medi-Cal program. Provide only the active Medi-Cal group provider numbers that are assigned to the Provider Type indicated on this form.

12. If applicable, provide the local business license or permit number(s) for any city or county or city and county where the group provider conducts its business activities. Attach a clearly legible copy to the application.

13. Provide the effective date of the local business license or permit number(s) indicated in number 12.

14. Provide the expiration date of the local business license or permit number(s) indicated in number 12.

15. List of Rendering Providers means the names of all individuals employed by the group provider at the business address on this application who are or will be providing services to clients eligible for the CCS program or GHPP. Indicate the first, middle initial, last name and title of each individual and his or her specialty and professional license number. If more space is needed to list rendering providers at the business address listed on this application, attach an additional sheet indicating all required information and labeling as item number 15. **Note:** Rendering providers, except certain dental providers, who are or will be providing services to clients eligible for the CCS program or GHPP at each Group Provider business address must submit the appropriate individual health care professional application. Dental Group Provider applicants must submit the following information for their Rendering Providers:

    - For Orthodontists and Oral Surgeons, submit a separate Individual Health Care Professional Paneling Application for each business address at which you are or will be providing services to clients eligible for the CCS program or GHPP.

    - For Endodontists, General Dentists, Pedodontists, Periodontists and Prosthodontists, attach a separate sheet(s) to this application indicating the required information and labeling as item number 15 for each business address at which you are or will be providing services to clients eligible for the CCS program or GHPP.

- Printed Name of individual signing the application means the first name, middle initial, last name and title of any individual acting on behalf of and with the authority to bind the Group Provider when applying to the CCS/GHPP programs as a Group Provider.

- Signature of the individual signing the application means the first name, middle initial, and last name of the individual acting on behalf of and with the authority to bind the Group Provider when applying to the CCS/GHPP programs as a Group Provider. An original signature **IN ANY COLOR OTHER THAN BLACK INK** is required. Indicate the date the application is signed.

CCS/GHPP Program Participation Requirements
By Provider Type

Audiologists: Audiologists must be licensed as such by the California Speech-Language Pathology and Audiology Board and have two years of clinical experience providing audiology services, one of which must have been with infants, children and adolescents. The experience may include the clinical fellowship year.

Dental: **Endodontists, General Dentists, Pediatric Dentists, Periodontists and Prosthodontists** must be licensed to practice dentistry by the California Board of Dental Examiners and limit their practice to the applicable dental specialty. An **Oral Surgeon** must be a licensed dentist who confines his or her practice to the specialty of oral surgery and is certified in oral and maxillofacial surgery by a specialty board recognized by the Commission on Dental Accreditation of the American Dental Association, or has successfully completed a course of advanced study in oral surgery of three years or more in programs recognized by the Council on Dental Education of the American Dental Association. An **Orthodontist** must be a licensed dentist who confines his or her practice to the specialty of orthodontics and who has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association, or has completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontists.

Occupational Therapists: Occupational therapists must be a graduate of an occupational therapy curriculum that is accredited by the American Occupational Therapy Association, the World Federation of Occupational Therapy, or another nationally recognized accrediting agency; be certified by the National Board for Certification in Occupational Therapy, and have at least one year of experience, beyond internship, providing occupational therapy to infants, children and adolescents with CCS-eligible medical conditions. Internship means the fieldwork performed following completion of the curriculum.

Optometrists: Optometrists must be licensed as such by the California State Board of Optometry and have documentation of experience in the care of children commensurate with services covered by the CCS/GHPP programs.

Orthotists: Orthotists must be certified by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

Physical Therapists: Physical therapists must be licensed as such by the Physical Therapy Board of California and must have one year of clinical experience, beyond internship, providing physical therapy to infants, children and adolescents with CCS-eligible medical conditions. Internship means the fieldwork performed following completion of the curriculum.

Physicians: (a) **Physicians** providing medical services to CCS/GHPP applicants or clients must be (1) licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California; and (2) certified by a member Board of the American Board of Medical Specialties. Physicians who are not board certified but who are eligible by training for the certifying examination may participate in the CCS program for not more than three years. (b) **Family Practice Physicians** must meet the requirements of (a) and have documented experience treating children with CCS-eligible medical conditions for at least five years, or have treated 100 or more such children.

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

Psychologists: Psychologists must be licensed as such by the California Board of Psychology, or credentialed by the California State Board of Education or Commission on Teacher Credentialing, and have a minimum of two years of clinical experience in which at least 50 percent of the individual's time has been spent counseling or testing children who have mental disorders, developmental disabilities, or CCS-eligible medical conditions.

Prosthetist: Prosthetists must be certified by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

Speech-Language Pathologists: Speech-language pathologists must be licensed as such by the California Speech-Language Pathology and Audiology Board and have two years of clinical experience providing speech-language pathology services, one year of which must have been with infants, children and adolescents with CCS-eligible medical conditions. The required experience may include the clinical fellowship year.

Other: Provider Types not listed require professional and/or business licensure, certification, registration or other approval to provide health care services.

California Children's Services and Genetically Handicapped Persons Programs
CHANGE OF INFORMATION REQUEST-
INDIVIDUAL HEALTH CARE PROFESSIONAL OR GROUP PROVIDER

IMPORTANT:

- **Refer to Attached Instructions to Complete this Form**
- **Type or Print Legibly**

Return Completed Form To:
Department of Health Services
Children's Medical Services Branch
Provider Services Unit
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 322-8702

SECTION I - MUST BE COMPLETED FOR REQUESTS FOR CHANGES

CGP Provider Number: _____ Provider Name: _____

Business Address (Office/Hospital): _____
Street City County State Zip Code

Business Telephone Number: | Fax Number: | E-mail Address:

SECTION II - TYPE OF CHANGE REQUESTED (Check all boxes below that apply and complete only the numbered item(s) applicable to the change(s) requested. Refer to instructions for completing this form.)

Check Box:

- ☐ Reactivate CGP Provider Number:
  - ☐ CCS Program ☐ GHPP ☐ Both
- ☐ Deactivate CGP Provider Number(s): Effective Date _____
  - ☐ CCS Program ☐ GHPP ☐ Both
- ☐ Add CCS Program Participation
- ☐ Add GHPP Participation
- ☐ Name Change
- ☐ Add Social Security Number
- ☐ Change Social Security Number
- ☐ Add Business Address
- ☐ Change Business Address
- ☐ Change Telephone Number
- ☐ Change Fax Number
- ☐ Add or Change E-mail address

Complete Numbers 7, 8 and 9 If Any Of The Next Four Boxes Are Checked:

- ☐ Change Pay-To Name
- ☐ Add Federal Tax ID Number
- ☐ Change Federal Tax ID Number
- ☐ Change Pay-To Address

_____

- ☐ Notification of New Medi-Cal Provider Number(s)
- ☐ Change Type of Practice
- ☐ Change in Type of Business
- ☐ Update Board Certification Status (Physician Only)
- ☐ Add Rendering Provider
- ☐ Delete Rendering Provider(s): Effective Date _____
- ☐ Other (Specify in Number 16)

1. Legal Name of Applicant: _____

2. Social Security Number: _____
(REQUIRED IF NOT USING FEDERAL TAX ID NUMBER - ATTACH COPY)

3. Business Address (Office/Hospital): _____
Street City County State Zip Code

4. Business Telephone Number: ( ) _____

5. Fax Number: ( ) _____

6. E-mail Address: _____

7. Pay-To Name: _____
Last Title First Middle Initial

8. Is the Pay-To Name a DBA name? ☐ Yes ☐ No

9. Federal Tax Identification Number: (ATTACH COPY) _____

10. Pay-To Address: _____
Street City State Zip Code

11. New Medi-Cal Provider Number(s): **Attach extra sheet if necessary and label as Number 11.**

For State Use Only:

Reviewed By: _____ Entered By: _____ Date: _____

12. Type of Medical or Dental Practice (CHECK ONE):	13. Type of Business (CHECK ONE):
☐ Solo Practice ☐ Dental School/Clinic ☐ Group (Must complete CCS/GHPP Group Provider Application)	☐ Sole Practitioner ☐ Corporation ☐ Partnership

14. Board Certification: (ATTACH COPY)

Name of Issuing Board	Specialty	Certificate Number	Date Certified	Expiration Date

15. Rendering Providers (See Instruction "Note") (ATTACH ADDITIONAL SHEET IF NECESSARY AND LABEL AS ITEM NUMBER 15):

Add or Delete (Circle One)	Name (FIRST, MIDDLE INITIAL, LAST, TITLE)	Specialty	Professional License Number
Add Delete			
Add Delete			
Add Delete			

16. Other Changes: Please Describe in Detail:

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

Printed Name and Title of the person authorized to bind the Provider and sign this application:

First Name Middle Initial Last Name _____ Title _____

Signature of the person authorized to bind the Provider IN ANY COLOR OTHER THAN BLACK INK:

First Name Middle Initial Last Name _____ Date _____

Privacy Statement
(As Required By Civil Code Section 1798 et seq.)

All information requested by the application 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 Services by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of paneling as a CCS/GHPP provider and issuance of the CGP provider number to obtain reimbursement from the CCS/GHPP programs. 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 CCS/GHPP programs. 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 Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

Did you remember to enclose (as applicable):

- ❑ Copy of Social Security Card
- ❑ Copy of Federal Tax Identification Number Verification
- ❑ Copy of Board Certification

INSTRUCTIONS FOR COMPLETING THE CHANGE OF INFORMATION REQUEST - INDIVIDUAL HEALTH CARE PROFESSIONAL OR GROUP PROVIDER

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

This form is for CCS/GHPP providers to complete when they need to change their paneling or billing information currently on file with the CCS/GHPP programs. Omission of any information or documentation on this form related to the requested change(s) or the failure to sign this form may result in delays in or inability to process this form. Providers may be contacted in writing if additional information and documentation is needed.

NOTE: Submission of this form to the CCS program or GHPP will not change any information related to your Medi-Cal provider information on file with the Medi-Cal program. Please contact the Medi-Cal program to change your Medi-Cal provider information.

Section I: The section must be completed for all requests for changes.

Enter your CGP Provider Number.

Provider's Name means the provider's first, middle initial and last name or the name of the provider's business.

Business Address means the office or hospital location where the applicant renders 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.

Enter Business Telephone Number.

Section II: Type of Change Requested means to check the applicable action(s) you would like made to the information currently on record. If checking "Other", please explain.

1. Legal Name of Provider means the new name under which the provider will be known to the CCS/GHPP programs. Item number 2 or number 7 must also be completed so that the Social Security Number or Federal Tax Identification Number is associated with the new Legal Name of Provider.

2. Provide the Social Security Number of the provider named in number 1. The Social Security Number is not required if the applicant is using their Federal Tax Identification Number requested in item number 9. Attach a clearly legible copy of the Social Security card if this number is being provided.

3. Business Address (OFFICE/HOSPITAL) means the new office or hospital location where the applicant renders 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 new primary business telephone number used at the business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the Business Telephone Number.

5. Fax Number means the new facsimile number used at the business address.

6. E-mail address means the new address to which electronic communications may be sent.

7. Pay-To Name means the new name of the person or business in which payment should be issued by the CCS/GHPP programs for authorized services rendered by the provider named in number 1. The Pay-To Name may be the legal name indicated in number 1, or another person or business chosen by the applicant. If this item is being changed, numbers 8 and 9 must also be completed. **Note**: See number 8.

8. Indicate Yes or No if the Pay-To Name is a Doing Business As (DBA) name. If Yes, the DBA name will be the name in which payment will be issued by the CCS/GHPP programs. Complete this item if numbers 7 or 9 are being changed.

9. Provide the Federal Tax Identification Number of the Pay-To Name indicated in number 7 as issued by the Internal Revenue Service (IRS). If this item is being changed, numbers 8 and 9 must also be completed. **Note**: If “Yes” is indicated in number 8, the Federal Tax Identification Number must be the number assigned by the IRS to the DBA Name. Attach a clearly legible copy of the Federal tax identification verification to this Change of Information Request form.

INSTRUCTIONS FOR COMPLETING THE CHANGE OF INFORMATION REQUEST - INDIVIDUAL HEALTH CARE PROFESSIONAL OR GROUP PROVIDER CONTINUED

10. The Pay-To address means the new location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit zip code.

11. Provide only the new Medi-Cal provider number(s) that relates to the type of service you provide under the CCS/GHPP programs.

12. Type of Medical or Dental Practice applies only to providers who are physicians or dentists. Indicate whether the provider is in a solo practice, is in a dental school or clinic, or is a member of a group. If group practice information is being changed, the provider must complete the CCS/GHPP Group Provider Application. A copy of this application may be obtained by calling the Provider Services Unit at the telephone number listed at the top of this request form.

13. Indicate the Type of Business that applies to your new business structure.

14. Board Certification applies only to providers who are physicians. Provide the name of the issuing board, specialty, certificate number, date certified, and expiration date, if applicable. Attach a clearly legible copy of your Board Certificate.

15. Rendering Providers means the names of all individuals employed by the group provider who are or will be providing services to clients eligible for the CCS/GHPP program(s), or who will no longer provide these services as a rendering provider of this group provider. Indicate whether the individual is being added or deleted, his or her first, middle initial, last name, title, specialty, and professional license number. If necessary, attach an additional sheet to this form listing all required information and labeling as item number 15. **Note:** The group provider must submit the appropriate individual health care professional application for participation in the CCS program or GHPP for each added rendering provider of its group.

16. Provide specific information on the change requested if it is not specifically listed in the Type of Change Requested item.

- Print the first name, middle initial, last name, and title of the individual acting on behalf of and with the authority to bind the provider and who is signing this form.

- Signature of the individual signing this form means the first name, middle initial, and last name of the individual acting on behalf of and with the authority to bind the provider. An original signature **IN ANY COLOR OTHER THAN BLACK INK** is required. Indicate the date the application is signed.