

Medi-Cal Dental Provider Directory/Referral Form

Medi-Cal Dental uses the following form to identify providers who are accepting Medi-Cal patients in their office. This form can be completed to update your status at any time. Providers participating in Medi-Cal Dental are automatically listed in the Provider Directory as accepting new patient referrals unless they complete and submit this form indicating otherwise.

- Yes, I am accepting new and existing Medi-Cal patients in my office. Please update my status on the Provider Directory. I understand I may request removal of my name from this list at any time by submitting a copy of this form.
- No, I am not accepting new Medi-Cal patient referrals at this time. Please do not include my name on your referral list and update the provider directory to indicate “not accepting new patients at this time”.

Dental License # _____ **Billing NPI #** _____

Business Name: _____

Fictitious Name/DBA Name: _____

Office Address: _____

Office Number: _____

Email Address: _____

Name and telephone number of person completing the form: _____

Is your office wheelchair accessible? Yes No

What other languages are spoken in your office? _____

List any dental specialties or services offered in your office (i.e., endodontic, general anesthesia, etc.): _____

What ages of children do you see in this practice? [Select all that apply]

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patients with special healthcare needs accepted (Select all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Motor impairment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Mildly challenging behavior | <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Other (please describe) |

Mail, email, fax, or call Medi-Cal Dental to be added to the referral list.

<p>Mail form to: Medi-Cal Dental Attn: Provider Correspondence P.O. Box 15609 Sacramento, CA 95852-0609</p>	<p>Email form to: Medi-CalDental EnrollmentDept@delta.org</p>	<p>Fax form to: (916) 853-6315</p>	<p>Call Medi-Cal Dental at: (800) 423-0507 Speak with a representative to get your questions answered by phone!</p>
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Comments:
