DHCS | Medi-Cal Dental

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal Dental Program (Medi-Cal Dental) Billing Intermediary service.

Please complete the enclosed Medi-Cal Dental Provider and Billing Intermediary Application/Agreement package and return it to:

The Medi-Cal Dental Program
Correspondence
P.O. Box 15609
Sacramento, California, 95852-0609

Please read all the instructions, included in the application package, carefully and complete each item requested. Incomplete application packages will be returned. It is your responsibility to report to the Medi-Cal Dental Program any modifications to information previously submitted within 35 days from the date of the change.

For more information about enrollment forms and the regulatory requirements for participation in the Medi-Cal Dental Program, please visit our website at **www.dental.dhcs.ca.gov** and click on the “Providers” link, or if you have any questions, contact the Telephone Service Center at 1-800-423-0507.

Sincerely,

Medi-Cal Dental
California Medi-Cal Dental Program
Correspondence

Enclosures

DHCS | Medi-Cal Dental

MEDI-CAL DENTAL PROVIDER AND BILLING INTERMEDIARY APPLICATION/AGREEMENT

Important:

- Type or print clearly, in blue ink.
- If you make corrections, please line through, date, and initial correction in ink.
- For Medi-Cal return completed Application/Agreement to:

Medi-Cal Dental Program
Correspondence
P.O. Box 15609 Sacramento,
CA 95852-0609
(800) 423-0507

Type of Request: Initial Registration Terminate Registration
Add Provider(s) Delete Provider(s)

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

PROVIDER INFORMATION			
Provider Name (full legal)			
Doing Business Name (if applicable)	National Provider Identifier (NPI)		
Provider Service Address (number, street)	City	State	ZIP Code
Contract Begin Date (mm/dd/yyyy) / /	Contract End Date (mm/dd/yyyy) / /	New Contract Yes No	
Contact Person Title/Position	Email Address		
Contact telephone number ( )	Driver's License or State-Issued Identification Number and State of Issuance (attach a legible copy)		

BILLER INFORMATION (If other than the provider of service)			
Owner Name (full legal name with 5% or more ownership/interest)	Biller Service Telephone Number ( )		
Biller Service Registration Number	Taxpayer Identification Number (TIN) issued by the IRS	Business License/Tax Certificate Number	
Business Address (number, street)	City	State	Zip
Owner contact number ( )	Driver's License or State-Issued Identification Number and State of Issuance (attach a legible copy)		
Full legal name(s) required as and any assumed Business names(s), address(es), and National Provider Identifier(s).			

Submit a legible copy of the following documents (required)

- Provider and Billing Intermediary Application/Agreement
- Billing Intermediary Service Contract(s)/Agreement(s)
- Biller Business License/Tax Certificate
- Provider Driver's License or State-Issued Identification Number Card
- Biller Driver's License or State-Issued Identification Number Card

The Provider and Biller agree to provide Medi-Cal Dental with the above information requested in order to verify qualifications to act as a Medi-Cal Dental Intermediary Biller.

PROVIDER SIGNATURE INFORMATION	
Full Printed Name	Title
Provider Signature (original signature required)	Date (mm/dd/yyyy) / /
BILLING SERVICE SIGNATURE INFORMATION	
Full Printed Name	Title
Owner (original signature required)	Date (mm/dd/yyyy) / /

MEDI-CAL DENTAL PROVIDER AND BILLING INTERMEDIARY APPLICATION/AGREEMENT

The Provider/Biller hereby acknowledges that he/she has read and understands the Medi-Cal Dental Program Provider Handbook and its contents, and agrees to comply with all Medi-Cal and Medi-Cal Dental requirements, to include future updates as posted on the Medi-Cal Dental web site: www.dental.dhcs.ca.gov

For a minimum period of five (5) years the Provider/Biller agrees to keep and maintain records of each such service rendered, the member or person to whom rendered, the date the service was rendered, and such additional information, which may be required by regulation. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, to the California Department of Health Care Services; California Department of Justice; Bureau of Medi-Cal Fraud, Office of the State Controller; California Department of Corporations; U. S. Department of Health and Human Services, or their duly authorized representatives.

The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds, and decertification of the Provider/Biller from participation in the Medi-Cal program and/or billing either electronically or manually.

The Provider/Biller agrees not to submit claims to or demand or otherwise collect reimbursement from a Medi-Cal member or from other persons on behalf of the member for any service included in the Medi-Cal program's scope of benefits in addition to claims submitted to the Medi-Cal program for that service, except to collect payments due where the benefits available under the Medi-Cal program duplicate those provided under other contractual or legal entitlements of the person or persons receiving them.

The Provider further agrees that dental care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability, marital status, or sexual orientation.

PROVIDER SIGNATURE INFORMATION		
Full Printed Name	Title	
Provider Signature (original signature required)		Date (mm/dd/yyyy) / /
BILLING SERVICE SIGNATURE INFORMATION		
Full Printed Name	Title	
Owner (original signature required)		Date (mm/dd/yyyy) / /