

APPLICATION FOR MEDI-CAL CERTIFICATION AS A PRIMARY CARE CLINIC PROVIDER

Initial application

Change of ownership application

Update

1. Clinic name (dba)

Street address (number, street)		P.O. Box	City	State	ZIP code
Telephone number ()	Fax number ()	Federal EIN number		Medi-Cal provider number(s)	

2. If this is an intermittent clinic, what is the name (dba) and address of the parent clinic:

Name _____

Street address (number, street)		P.O. Box	City	State	ZIP code
Telephone number ()	Fax number ()	Federal EIN number		Medi-Cal provider number(s)	

3. Legal name of entity (corporation) owning clinic

Street address (number, street)		P.O. Box	City	State	ZIP code
Telephone number ()	Fax number ()	Federal EIN number		Medi-Cal provider number(s)	

NOTE: The entity must complete this form for each clinic owned and/or operated in California.

Questions 4 through 8 apply to the clinic listed in number 1 above.

4. Specific type of service, advice, and/or treatment to be provided:

5. Source of funds and income for clinic operation:

6. Check each day of the week clinic is open:	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> T	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F	<input type="checkbox"/> S
7. Enter the number of hours the clinic is open under each day of the week checked:							
8. Enter the number of hours patients are seen under each day of the week checked:							

I declare under penalty of perjury that the statements on this document are correct to my knowledge.

Signature	Date
Print name	Title