Provider Not On File Form

Instructions		
Current copies of the following documents must be submitted with this form. *** Completed W-9** *** DHCS Rate Letter** (Skilled Nursing/LTC Only)		
Are you a California State Medi-Cal Approved Provider? ☐ **Yes** ☐ **No**		
Practice Type (select one)		
☐ Individual Practice	☐ Group Practice	☐ Hospital
☐ Ancillary Provider	☐ Skilled Nursing/LTC *DHCS Rate Letter Required	☐ Durable Medical Equipment
Type of Specialty Care Provided:		

Practice Site Information			
Facility, Practice, or individual Provider Name			
Address			
City	State	County	ZIP
Main Office Phone #		FAX	
Contact Name		Title	
Contact Email		Contact Phone #	

Payment Information	
Tax ID #:	Billing NPI #:
*W-9 Attached? (required): ☐ **Yes**	**1099 will be mailed to the address listed on the W-9**

Pay To Address (If different than above)		
Name		
Address		
City	State	ZIP
Contact Name	Title	
Direct Telephone	FAX	Contact Email

Information Verification
I hereby affirm that the information submitted on these documents are current, correct, and complete to the best of my knowledge.
Name (print): ______________________ Signature: ______________________
Title: ______________________ Date: ______________________

Complete a W-9 and return it with this form to Providers Relations Fax# 707-639-5503 or click the Submit button to email.