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

CLEAR PRINT

☐ 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:

	☐ S	☐ M	☐ T	☐ W	☐ Th	☐ F	☐ S
6. Check each day of the week clinic is open:							
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