California Children's Services
CHANGE OF INFORMATION REQUEST-
INDIVIDUAL AND ALLIED HEALTH CARE PROFESSIONALS

IMPORTANT:

- **Refer to Attached Instructions to Complete this Form**
- **Type or Print Legibly**

Return Completed Form To:
Department of Health Services
Children's Medical Services Branch
Provider Services Unit
MS 8100
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 322-8702

SECTION I - MUST BE COMPLETED FOR REQUESTS FOR CHANGES

CGP Provider Number: _____ Provider Name: _____

Business Address (Office/Hospital): _____
Street City County State Zip Code

Business Telephone Number: | Fax Number: | E-mail Address:

SECTION II - TYPE OF CHANGE REQUESTED (**Check all boxes below that apply and complete only the numbered item(s) applicable to the change(s) requested. Refer to instructions for completing this form.**)

Check Box:

- ❑ Reactivate CGP Provider Number:
  - ☐ CCS Program ☐ GHPP ☐ Both
- ❑ Deactivate CGP Provider Number(s): Effective Date _____
  - ☐ CCS Program ☐ GHPP ☐ Both
- ❑ Add CCS Program Participation
- ❑ Add GHPP Participation
- ❑ Name Change
- ❑ Add Social Security Number
- ❑ Change Social Security Number
- ❑ Add Business Address
- ❑ Change Business Address
- ❑ Change Telephone Number
- ❑ Change Fax Number
- ❑ Add or Change E-mail address

Complete Numbers 7, 8 and 9 If Any Of The Next Four Boxes Are Checked:

- ❑ Change Pay-To Name
- ❑ Add Federal Tax ID Number
- ❑ Change Federal Tax ID Number
- ❑ Change Pay-To Address _____
- ❑ Notification of New Medi-Cal Provider Number(s)
- ❑ Change Type of Practice
- ❑ Change in Type of Business
- ❑ Update Board Certification Status (Physician Only)
- ❑ Add Rendering Provider
- ❑ Delete Rendering Provider(s): Effective Date _____
- ❑ Other (Specify in Number 16)

1. Legal Name of Applicant: _____

2. Social Security Number: (REQUIRED IF NOT USING FEDERAL TAX ID NUMBER -ATTACH COPY) _____

3. Business Address (Office/Hospital): _____
Street City County State Zip Code

4. Business Telephone Number: ( ) _____

5. Fax Number: ( ) _____

6. E-mail Address: _____

7. Pay-To Name: _____
Last Title First Middle Initial

8. Is the Pay-To Name a DBA name? ☐ Yes ☐ No

9. Federal Tax Identification Number: (ATTACH COPY) _____

10. Pay-To Address: _____
Street City State Zip Code

11. New Medi-Cal Provider Number(s): **Attach extra sheet if necessary and label as Number 11.**

For State Use Only:

Reviewed By: _____ Entered By: _____ Date: _____

12. Type of Medical or Dental Practice (CHECK ONE):	13. Type of Business (CHECK ONE):
☐ Solo Practice ☐ Dental School/Clinic ☐ Group (Must complete CCS/GHPP Group Provider Application)	☐ Sole Practitioner ☐ Corporation ☐ Partnership

14. Board Certification: (ATTACH COPY)

Name of Issuing Board	Specialty	Certificate Number	Date Certified	Expiration Date

15. Other Changes: Please Describe in Detail:

I hereby affirm that the information submitted on this form, and any attachments, are true, accurate, and complete to the best of my knowledge and belief and is furnished in good faith.

Printed Name and Title of the person authorized to bind the Provider and sign this application:

First Name Middle Initial Last Name Title

Signature of the person authorized to bind the Provider IN ANY COLOR OTHER THAN BLACK INK:

First Name Middle Initial Last Name Date

Privacy Statement
(As Required By Civil Code Section 1798 et seq.)

All information requested by the application is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of paneling as a CCS/GHPP provider and issuance of the CGP provider number to obtain reimbursement from the CCS/GHPP programs. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the CCS/GHPP programs. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Health Care Financing Administration, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

Did you remember to enclose (as applicable):

- ☐ Copy of Social Security Card
- ☐ Copy of Federal Tax Identification Number Verification
- ☐ Copy of Board Certification

INSTRUCTIONS FOR COMPLETING THE CHANGE OF INFORMATION REQUEST - INDIVIDUAL HEALTH CARE PROFESSIONAL OR GROUP PROVIDER

For assistance in completing this application, please call
Children's Medical Services Branch, Provider Services Unit
(916) 322-8702

This form is for CCS/GHPP providers to complete when they need to change their paneling or billing information currently on file with the CCS/GHPP programs. Omission of any information or documentation on this form related to the requested change(s) or the failure to sign this form may result in delays in or inability to process this form. Providers may be contacted in writing if additional information and documentation is needed.

NOTE: Submission of this form to the CCS program or GHPP will not change any information related to your Medi-Cal provider information on file with the Medi-Cal program. Please contact the Medi-Cal program to change your Medi-Cal provider information.

Section I: The section must be completed for all requests for changes.

Enter your CGP Provider Number.

Provider's Name means the provider's first, middle initial and last name or the name of the provider's business.

Business Address means the office or hospital location where the applicant renders services, including the street name and number, room or suite number or letter, city, county, state, and 5-digit zip code. A post office box or commercial box is not acceptable.

Enter Business Telephone Number.

Section II: Type of Change Requested means to check the applicable action(s) you would like made to the information currently on record. If checking "Other", please explain.

1. Legal Name of Provider means the new name under which the provider will be known to the CCS/GHPP programs. Item number 2 or number 7 must also be completed so that the Social Security Number or Federal Tax Identification Number is associated with the new Legal Name of Provider.

2. Provide the Social Security Number of the provider named in number 1. The Social Security Number is not required if the applicant is using their Federal Tax Identification Number requested in item number 9. Attach a clearly legible copy of the Social Security card if this number is being provided.

3. Business Address (OFFICE/HOSPITAL) means the new office or hospital location where the applicant renders services, including the street name and number, room or suite number or letter, city, county, state, and 5-digit zip code. A post office box or commercial box is not acceptable.

4. Business Telephone Number means the new primary business telephone number used at the business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the Business Telephone Number.

5. Fax Number means the new facsimile number used at the business address.

6. E-mail address means the new address to which electronic communications may be sent.

7. Pay-To Name means the new name of the person or business in which payment should be issued by the CCS/GHPP programs for authorized services rendered by the provider named in number 1. The Pay-To Name may be the legal name indicated in number 1, or another person or business chosen by the applicant. If this item is being changed, numbers 8 and 9 must also be completed. **Note**: See number 8.

8. Indicate Yes or No if the Pay-To Name is a Doing Business As (DBA) name. If Yes, the DBA name will be the name in which payment will be issued by the CCS/GHPP programs. Complete this item if numbers 7 or 9 are being changed.

9. Provide the Federal Tax Identification Number of the Pay-To Name indicated in number 7 as issued by the Internal Revenue Service (IRS). If this item is being changed, numbers 8 and 9 must also be completed. **Note**: If “Yes” is indicated in number 8, the Federal Tax Identification Number must be the number assigned by the IRS to the DBA Name. Attach a clearly legible copy of the Federal tax identification verification to this Change of Information Request form.

INSTRUCTIONS FOR COMPLETING THE CHANGE OF INFORMATION REQUEST - INDIVIDUAL HEALTH CARE PROFESSIONAL OR GROUP PROVIDER CONTINUED

10. The Pay-To address means the new location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit zip code.

11. Provide only the new Medi-Cal provider number(s) that relates to the type of service you provide under the CCS/GHPP programs.

12. Type of Medical or Dental Practice applies only to providers who are physicians or dentists. Indicate whether the provider is in a solo practice, is in a dental school or clinic, or is a member of a group. If group practice information is being changed, the provider must complete the CCS/GHPP Group Provider Application. A copy of this application may be obtained by calling the Provider Services Unit at the telephone number listed at the top of this request form.

13. Indicate the Type of Business that applies to your new business structure.

14. Board Certification applies only to providers who are physicians. Provide the name of the issuing board, specialty, certificate number, date certified, and expiration date, if applicable. Attach a clearly legible copy to the Change of Information Request form.

15. Provide specific information on the change requested if it is not specifically listed in the Type of Change Requested item.

- Print the first name, middle initial, last name, and title of the individual acting on behalf of and with the authority to bind the provider and who is signing this form.

- Signature of the individual signing this form means the first name, middle initial, and last name of the individual acting on behalf of and with the authority to bind the provider. An original signature **IN ANY COLOR OTHER THAN BLACK INK** is required. Indicate the date the application is signed.