

## General Acute Care Hospital and Acute Psychiatric Hospital Change of National Provider Identifier Application Checklist

The following is a list of application forms and supporting documents required for a complete application packet. Failure to include each of the forms and documents will delay processing.

**CHECKLIST AND INSTRUCTIONS-** *Please submit your documents in this order*

### REQUIRED DOCUMENTS FOR A CHANGE OF NATIONAL PROVIDER IDENTIFIER

<i>Use this space to check if included</i>	<b>Forms and supporting documents</b>	<b>Additional Instructions (Each form listed also has instructions on the form)</b>
	Cover Letter	<p><b>COVER LETTER</b></p> <p>Letter on company letterhead with the following information:</p> <ul style="list-style-type: none"> <li>• License number</li> <li>• Facility name and ID number (if known)</li> <li>• Brief description of request</li> <li>• Contact information (name, title, phone number, and e-mail address)</li> <li>• Emergency Contact Information (name, email, alternate email, phone, fax, and phone number that will receive text messages). The Department will use this information to contact the provider in the event of an emergency using the California Health Alert Network (CAHAN). All information provided must allow CAHAN to contact the provider on a 24/7/365 basis for distribution of health alerts. For additional information: <a href="https://www.calhospitalprepare.org/cahan">CAHAN</a> (https://www.calhospitalprepare.org/cahan)</li> <li>• Signature</li> </ul>
	HS 200	<p><b>LICENSING &amp; CERTIFICATION APPLICATION</b> (Title 22 California Code of Regulations (CCR) section 70107)</p> <p><b>Tips</b></p> <ul style="list-style-type: none"> <li>• Page 2, section B, Item 6 — An organization must own 100% of the licensee to be considered a parent company. This parent company will have its own Employer Identification Number (EIN)</li> </ul>

<i>Use this space to check if included</i>	<b>Forms and supporting documents</b>	<b>Additional Instructions (Each form listed also has instructions on the form)</b>
		<ul style="list-style-type: none"> <li>Page 3, section C, Item 7 — When listing the names of individuals owning direct or indirect ownership of the facility in section C, provide the EIN (do not enter a social security number in this field)</li> </ul>

### MEDI-CAL CERTIFICATION DOCUMENTS

<i>Use this space to check if included</i>	<b>Forms and supporting documents</b>	<b>Additional Instructions (Each form listed also has instructions on the form)</b>
	DHCS 9098	<p><b>MEDI-CAL PROVIDER AGREEMENT</b></p> <ul style="list-style-type: none"> <li>Do not leave any questions blank. Enter “same” or “N/A” if not applicable</li> <li>The mailing address must be the same as reported on the HS 200 form</li> <li>Notarized signature page is required</li> <li>Submit the "Acknowledgement" page from the Notary Public, if applicable</li> </ul>
	Supporting Documents	<p><b>IRS- INTERNAL REVENUE SERVICE DOCUMENTATION</b> (if applicable)</p> <p>Submit <b>one</b> of the following IRS tax documents showing entity’s legal name and Tax Identification Number:</p> <ul style="list-style-type: none"> <li>Form 941- Employer’s Quarterly Federal Tax Return</li> <li>Form 8109-C- FTD Address Change</li> <li>Letter 147-C- EIN Confirmation Notification</li> <li>Form SS-4- Confirmation Notification</li> </ul>