California Department of PublicHealth

Center for Health Care Quality
Licensing and Certification Program
Centralized Applications Branch

Intermediate Care Facility/Developmentally Disabled (ICF/DD)
ICF/DD-Habilitative (ICF/DD-H)
Report of Change Application Checklist for
Change of National Provider Identifier

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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Cover Letter	**COVER LETTER** Letter on company letterhead with the following information: • License number • Facility name and address • Facility ID number (if known) • Brief description of request • Contact information (name, title, phone number, and e-mail address) • 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: CAHAN (https://www.calhospitalprepare.org/cahan) • Signature

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** **Tips** • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent company. This parent company will have its own Employer Identification Number (EIN) • 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)

MEDI-CAL CERTIFICATION DOCUMENTS

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	DHCS 9098	**MEDI-CAL PROVIDER AGREEMENT** • Do not leave any questions blank. Enter “same” or “N/A” if not applicable • The mailing address must be the same as reported on the HS 200 form • Notarized signature page is required • Submit the "Acknowledgement" page from the notary public, if applicable
	CMS 855A	**MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION** • This application is from the Federal Department of Health and Human Services • The completed application should be mailed directly to the appropriate fiscal intermediary • This document does not go to CAB