California Department of PublicHealth

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

Primary Care Clinic (PCC) - Affiliate Mobile Clinic 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 (only applicable for CHOW) • Facility name and ID number (if known) • Brief description of request • Days and hours of operation • Locations serviced by mobile unit • Contact information (name, title, phone number, and email 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: California Health Alert Network (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	**LICENSING & CERTIFICATION APPLICATION** **Tips** • 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) • 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	**MEDICAL 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