

Merced County Department of Mental Health
Medi-Cal Network Provider Application

Merced County Department of Mental Health
P.O. Box 2087
Merced, CA 95344

MEDI-CAL NETWORK PROVIDER APPLICATION

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Merced County Department of Mental Health
P.O. Box 2087
Merced, CA 95344
Phone: (209) 381-6800
Fax: (209) 725-3807

Dear Applicant,

Thank you for your interest in participating as a Medi-Cal Network Provider in the Mental Health Plan of Merced County Department of Mental Health. Please read the enclosed General Instructions prior to completing the application.

Upon receiving your completed application, you will be notified by mail in regards to your status as a Medi-Cal Provider in the Mental Health Plan of Merced County Department of Mental Health.

Please note that you must be an approved provider before the MHP is able to render payment for services.

Should you have any questions regarding this application, please feel free to contact me at (209) 381-6806. Thank you.

Sincerely,

Evelyn Egger, RN, Quality Improvement Program Manager
Email: EEgger@co.merced.ca.us

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GENERAL INSTRUCTIONS:

- Application must be typed or printed legibly; curriculum vitae will not be accepted in lieu of a completed application.
- If there is insufficient room for any question, additional sheets will be accepted. Please make reference to the question number if an additional sheet is used.
- Please include:

Copy of current DEA Certification, if applicable
Copy of current Professional License
Copy of Professional Board Certification, if applicable
Copy of current Professional Liability Insurance Certificate
Copy of current W-9

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PROVIDER INFORMATION:

Last Name: _____ First Name: _____ MI: _____
SSN/Tax ID: _____ Gender: _____ DOB: _____
License Type: _____ Specialty: _____ NPI: _____

PRIMARY OFFICE(S): If more than one, please use separate sheet.

Office Address: _____

Billing Address: Same as office address _____

Phone Number: _____ Fax Number: _____

- | | | | | | |
|----|---|--------------------------|-----|--------------------------|----|
| 1. | Is your office wheelchair accessible? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. | Does your office have parking on site? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. | Is your office located near public transportation? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. | Do you dispense and maintain medications? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. | Do you have a Fire Clearance? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. | Are you available 24/7 with a "back-up" provider?
If yes, who is the provider? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
- _____

PRACTICE INFORMATION:

Make checks payable to: _____
If practicing as a corporation, identify name: _____

If you are part of a group, list names of other providers in group who will also participate:

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Are you currently employed elsewhere in addition to private practice? Yes No
 If yes, please provide employer information:

Employer Name: _____ Phone: _____
 Address: _____ Contact: _____

LICENSE INFORMATION:

TYPE OF LICENSE	LICENSE #	STATE ISSUED	DATE ISSUED

Medi-Cal Provider #		Medicare UPIN:	
DEA #:		DEA Expiration Date:	

BOARD CERTIFICATION:

Have you applied for board certification? Yes No

NAME OF BOARD	CERT. NUMBER	CERT. DATE	EXPIRATION DATE

Are you currently credentialed with any other Mental Health Plan? Yes No
 If yes, please list name of county/counties:

CURRENT HOSPITAL AFFILIATION(S), if applicable:

NAME	TEAM/DEPT	APPT DATE	STATUS

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CONTINUING EDUCATION:

List all postgraduate activities in which you have attended or for which you have received credit within the past two years.

ACTIVITY	AGENCY	HOURS	DATE COMPLETED

PROFESSIONAL LIABILITY:

INSURANCE CARRIER	POLICY HOLDER	LIMITS OF LIABILITY	EFFECTIVE DATE:	EXPIRATION DATE:

LANGUAGES:

Please identify languages, other than English, including American Sign Language, in which you are proficient:

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Disorder	Yes	No	Disorder	Yes	No
Adjustment Disorders			Feeding and Eating Disorders		
Anxiety Disorders			Gender Identity Disorders		
Attention Deficit/Disruptive Disorders			Impulse Control Disorders		
Bipolar Disorders (Moderate)			Medication Induced Movement Disorders		
Bipolar Disorders (Severe)			Mood Disorders (Moderate)		
Dissociative Disorders			Mood Disorders (Severe with Psychosis)		
Eating Disorders			Disorders of Infancy		
Elimination Disorders			Paraphilias		
Factitious Disorders			Pervasive Developmental Disorders		
Personality Disorders			Schizophrenia		

CULTURAL COMPETENCE: Please identify:

ATTESTATION:

Question	Yes	No
Has your clinical license or DEA registration ever been revoked, suspended, or limited?		
Have you been the recipient of adverse actions, or surrendered clinical privileges while under investigation for possible actions such as: revocation, suspension, limitation, disciplinary review, denial, or cancellation of license?		
Is any action pending by: Medicare, Medicaid, any public program, hospital medical staff, clinical group, independent practice association, professional school faculty or other health delivery entity or system?		
Have you ever been convicted of a felony?		
Have you ever had any professional liability claims? If yes, please provide details on the back of this page.		

I certify that the information provided on this application is accurate and complete. I authorize the Mental Health Plan to verify all of the information provided in this application.

Signature/Title/Date

STATEMENT OF UNDERSTANDING

I hereby certify that the information provided in this Medi-Cal Network Provider Application is true and accurate and reflects my current level of training, experience, and demonstrates competence to practice within my clinical expertise. I understand that I have the burden and legal responsibility to provide true and adequate information to demonstrate my professional competence, character, moral ethics, and other qualifications.

I hereby consent to the disclosure and inspection of information and documents relating to my credentials and qualifications by and between Merced County Department of Mental Health and other health care organizations, licensing authorities, businesses and individuals acting as their agents for the purpose for the evaluation of this credentialing or re-credentialing application regarding my professional training, experience, character, conduct, judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken in safeguarding the privacy of patients and the confidentiality of patient records, and to protect peer review information from being further disclosed.

I hereby affirm that the information submitted and any addenda thereto are true to the best of my knowledge and belief and are furnished in good faith. I understand that significant omissions or misrepresentation may result in denial or termination of my privileges.

Signature/Title/Date