Provider: Medi-Cal Hardcopy Biller Notification Form

Page updated: August 2020

Provider Name: _____

DBA (if applicable): _____

Provider Number: _____

Provider Address: _____

_____

Previous submitter name (if applicable): _____

Billing Service: _____

Billing Service Address: _____

_____

Effective Date: _____

Provider Signature: _____ Date: _____

This form is to be completed and returned to:

Department of Health Care Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413