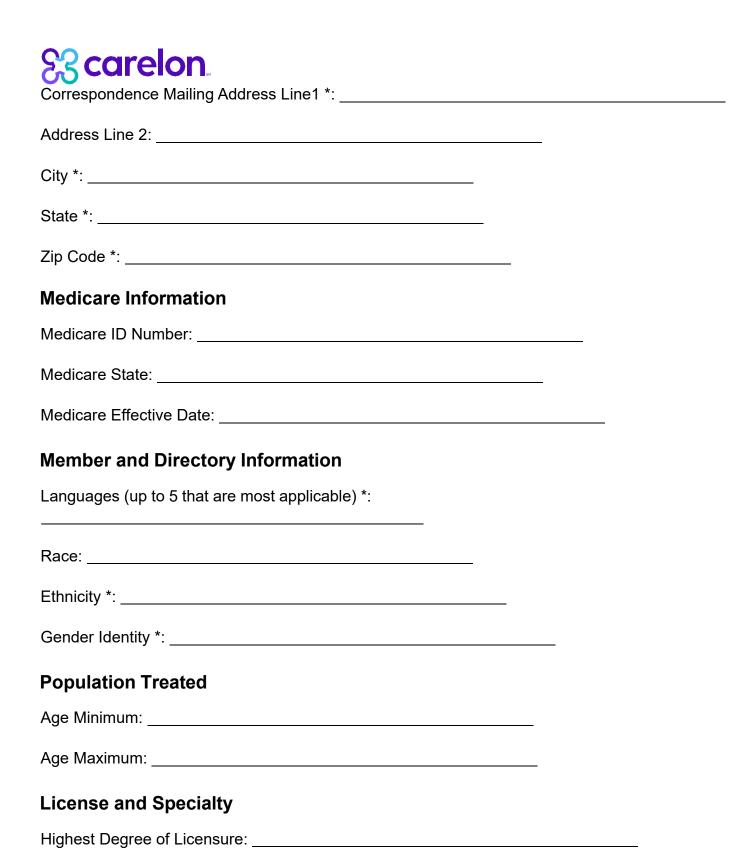


Provider Enrollment - Join an Existing Group

<u>Disclaimer</u> - This form is intended only for providers who are unable to submit an online application through Availity to join an existing group. Submissions for any other purpose will not be reviewed or receive a response.

Group Information
Group NPI*:
Group TIN*:
Group Name/DBA Name*:
Provider Basic Information
CAQH Number:
NPI Number *:
Personal Information
Provider First Name:
Provider Middle Name:
Provider Last Name *:
Preferred Provider Pronouns:
Date of Birth *:
US Citizen? (Yes / No) *:
SSN *:
Correspondence Phone *:
Ext:
Phone Type:
Correspondence Email*:



License Effective Date: License Expiration Date:

Provider License Number *: _____

Provider License State: _____



Documents Required

- 1. Resume*
- 2. Malpractice Declaration Form*
- 3. California Medi-Cal Enrollment
- 4. Ohio Department of Medicaid Addendum ODM 10235 R.3/2022
- 5. DEA* (required if you prescribe controlled substances)
- 6. CDS
- 7. Board Certification*
- 8. Licenses*