



Behavioral Health Administration

CaSonya Thomas, MPA, CHC Director

Medi-Cal Certification Packet Approval Form

Provider Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Site Location: \_\_\_\_\_  
Street Address

City State Zip Code Phone

Business Address (If different from above):

Corporation Name

Street Address

City State Zip Code Phone

Contact Person: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Medi-Cal Certification Packet Checklist: (Check-off completed documents)

- Letter of Intent Fire Notice/Clearance
SD/MC Provider Cert. Application Mode of Service
SD/MC Provider Agreement W-9
MediCal Provider Data Form Reporting Unit Setup Form
MediCal Provider Disclosure Statement Request for Cost Center

For Contract Agencies Submit Schedule A Indicating Contracted Modes

I HAVE REVIEWED AND APPROVED THE COMPLETED MEDI-CAL CERTIFICATION PACKET SUBMITTED BY THE ABOVE PROVIDER.

Signature: Regional Program Manager Date

Signature: Sarah Eberhardt-Rios, Deputy Director, MPA Date

BOP022 (12/14)

BOARD OF SUPERVISORS

ROBERT A. LOVINGOOD First District

JANICE RUTHERFORD Chair, Second District

JAMES RAMOS Third District

CURT HAGMAN Fourth District

JOSIE GONZALES Fifth District

GREGORY C. DEVEREAUX Chief Executive Officer