PROVIDER ENROLLMENT INQUIRY FORM

Office of Family Planning

Submit by Email

If you experience problems using "submit by email" please email ProviderServices@dhcs.ca.gov.

CONTACT NAME: DATE:

PHONE NUMBER:

SITE NPI: CONTACT EMAIL:

SITE NAME:

SITE ADDRESS:

MEDI-CAL STATUS: ☐ Enrolled ☐ Not Enrolled ☐ Pending

REASON FOR INQUIRY

STATUS OF FAMILY PACT APPLICATION

DATE APPLICATION SENT DEFICIENCY LETTER DATE

COMMENT:

PROGRAM

- ☐ CHANGE OF NAME
- ☐ CHANGE OF ADDRESS
- ☐ CHANGE OF OWNERSHIP
- ☐ CHANGE OF PROVIDER TYPE
- ☐ ADDING A SITE
- ☐ AFFILIATE CLINIC
- ☐ INTERMITTENT CLINIC
- ☐ MOBILE CLINIC

COMMENT:

ORIENTATION

- ☐ DATE ATTENDED
- ☐ DATE REGISTERED
- ☐ ARE YOU PROVISIONALLY ENROLLED? ☐ YES ☐ NO

COMMENT: