COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
CHILD HEALTH AND DISABLILITY PREVENTION (CHDP) PROGRAM

CHDP SUPPLEMENTAL APPLICATION

Important:
- ✓ **Refer to attached instructions when completing form.**
- ✓ Type or print clearly, in ink.
- ✓ If you must make corrections, please line through, initial in ink.

RETURN COMPLETED FORM TO:
CHDP Headquarters
9320 Telstar Ave. Ste. 226
El Monte, CA 91731
ATTN: Provider Desk

SECTION I. GENERAL INFORMATION

1. Legal Name (as listed with Medi-Cal)		2. NPI Provider Number (as related to with site listed on SECTION I # 3)	
3. Business Address (number, street)		City	Zip Code
4. Business Telephone Number ( )	Fax Number ( )	Email	
5. Name of Contact Person		6. Phone # of Contact Person ( )	
7. Provider Type ☐ Solo Practice ☐ Group Practice ☐ Government ☐ Teaching Institution ☐ Clinic (*please specify type*: _____) ☐ Other (*please specify*: _____)			

SECTION II. CHANGE ACTION REQUESTED

☐ Pay To Address ☐ Provider Category ☐ Clinical Laboratory Improvement Amendment (CLIA)

☐ Pay To Name (Use Sect. IV Comments) ☐ Add/Delete Clinician(s) ☐ Provider Applicant (*must complete DHCS 4490, 4491)

☐ Provider Disenrollment ☐ Tax ID/SSN ☐ Legal Name as listed with Medi-Cal (*must complete DHCS 4490, 4491)

☐ Telephone Number ☐ Fax Number ☐ Email

☐ NPI Provider Number (*must complete DHCS 4490, 4491. **Old number will be inactivated)

SECTION III. NEW INFORMATION *(Complete only the boxes specific to the action requested.)*

1. NPI Provider Number:	**2. Tax ID/SSN:** (attach copy)	**3. CLIA #** (attach copy of certificate)	**4. Provider Category**
5. Pay to address (number, street)		**City**	**Zip Code**
6. Telephone # ( )	**7. Fax #** ( )	**8. Email**	
9. Provider Applicant's Name		**10. Legal Name** (as listed with Medi-Cal)	

11. Add Rendering Clinician(s) Name/Title (*Copy this form if additional space is required*)	**Professional License #** (*Attach copy of certificate*)	**Specialty** (*Attach copy of certificate*)	**CHDP Experience**	**CHDP Staff ONLY**	
				App'd	**Not App'd**
I.					
II.					
III.					

SECTION III. NEW INFORMATION (CONTINUED)

12. Delete Rendering Clinician(s) **Name/Title** (*Copy this form if additional space is required*)	**Professional License #**	**Effective Date**
I.		
II.		
III.		

13. Voluntary Disenrollment Effective Date:	**Reason** (*Attach letter*)

SECTION IV. COMMENTS *(Provide any additional information necessary)*

Privacy Statement (as required by Civil Code, Section 1798 et seq.)

All information requested by the application is required by the Department of Health Care Services (DHCS) by the authority of Title 17, Section 6860. The consequences of not supplying the requested information are denial of enrollment as a CHDP provider and no issuance of the provider number to obtain reimbursement from the CHDP Program. Any information provided will be used to verify eligibility to participate as a provider in the CHDP Program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by the DHCS, contact the Provider Services Unit of Children's Medical Services Branch, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413, (916) 322-8702.

The Provider Applicant hereby affirms that all CHDP Clinicians meet the minimum qualification requirements as specified in the CHDP Provider Manual and have agreed to abide by the regulatory requirements and policies of the CHDP Program. The information submitted on this application and any attachments is true, accurate, and complete to the best of the Provider Applicant's knowledge and belief and are furnished in good faith. The Provider Applicant understands failure to comply with the requirements of the CHDP Program may result in disenrollment.

Printed name of Provider Applicant *(First)* *(Middle initial)* *(Last)*	
Provider Applicant's signature **IN BLUE INK ONLY**	Date

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FOR LOCAL CHDP PROGRAM USE ONLY

Check Regional office: ☐ **East** ☐ **S/West** ☐ **S/West/Sat.** ☐ **North**	**Director Signature:**	**Date:**