California Child Health and Disability Prevention (CHDP) Program
CHDP LABORATORY PROVIDER APPLICATION

IMPORTANT:
- Refer to attached instructions to complete this form.
- Type or print legibly.
- Return completed form to:
  Children's Medical Services Branch
  Provider Services Unit
  MS 8100
  P.O. Box 997413
  Sacramento, CA 95899-7413
- Find CHDP program information at:
  http://www.dhcs.ca.gov/services/chdp.

For Local CHDP Program Use Only

CHDP Program			
Address (number, street)			
City	County	State: CA	ZIP code

Application for participation as *(check one):*
(Please see instructions for description.)

☐ Clinical laboratory ☐ Clinical laboratory (including blood lead)

1. Legal name of laboratory	2. Provider number(s) *(see instructions)*	3. State laboratory license/ registration number

4. Business name if different from legal name

Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)	

5. Business address (laboratory location)

Number, street | City | County | State | ZIP code

6. Business telephone number ( )	7. Fax number ( )	8. E-mail address

9. Pay-to name (last) (first) (middle initial)	10. Federal Employer Identification Number (FEIN) *(attach a copy)*

11. Pay-to address

Number, street | City | State | ZIP code

12. Type of business *(check one)*:

☐ Sole proprietor ☐ Corporation ☐ Partnership ☐ Limited liability corporation ☐ Other: _____ *(please specify)*

Principal owners

13. Director(s) of laboratory

Name Address

Name Address

14. CLIA certificate number *(attach a copy)*	15. Certificate expiration date	16. Number of testing sites for this CLIA number

17. Is this facility in a licensed acute care hospital? ☐ Yes ☐ No

For STATE Use Only

Reviewed by CMS Provider Services Unit *(print name)*	Signature	`	Date enrolled

The laboratory applicant hereby agrees to abide by the statutory and regulatory requirements and policies of the CHDP Program. The information submitted on this application and any attachments are true, accurate, and complete to the best of the Laboratory Applicant's knowledge and belief and are furnished in good faith. The Laboratory Applicant understands that failure to comply with the requirements of the CHDP Program may result in disenrollment.

18. Printed name of Laboratory Director *(first)*	*(middle initial)*	*(last)*

19. Laboratory Director signature ***IN BLUE INK ONLY***	Date

20. Printed name of Owner *(first)*	*(middle initial)*	*(last)*

21. Owner signature ***IN BLUE INK ONLY***	Date

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

All information requested on 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 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.

INSTRUCTIONS FOR COMPLETION OF THE CHDP LABORATORY PROVIDER APPLICATION

For assistance in completing this application, please call the CMS Branch, Provider Services Unit at (916) 322-8702.

Laboratory providers wishing to enroll as a provider with the CHDP Program must complete an application and be approved by the California Children's Medical Services Branch in order to bill the CHDP Program for CHDP services.

Upon review and approval of the completed application, the applicant will be assigned a provider number to use when billing the CHDP Program. Omission of any information or documentation on this application or the failure to sign this application may result in delays in processing or inability to process this application. Applicants may be contacted orally or in writing if additional information and documentation are needed.

Application for participation as: Mark the appropriate box indicating the type of laboratory for which you are applying.

A **clinical laboratory** must be:

- Licensed or registered by the Department pursuant to the Business and Professions Code, Section 1265; and
- Hold the appropriate certification or approval under CLIA for the level of testing done in the laboratory.

A **clinical laboratory (including blood lead)** must be:

- Licensed or registered by the Department pursuant to the Business and Professions Code, Section 1265;
- Certified or approved under CLIA for nonwaived testing and for subspecialty toxicology, analyte blood lead; and
- Enrolled in, and qualified as proficient in blood lead level analysis by, the California Blood Lead Proficiency Assurance Program administered by Department, refer to http://www.dhs.ca.gov/ehlb/BioChem or (510) 620-2800.

1. Legal name of laboratory means the name under which the applicant is applying for a CHDP provider number and listed with the IRS.
2. Provider number(s): Provide all active provider numbers of the applicant. Provide only the active provider numbers that are assigned to the business address indicated on this form.
3. State laboratory license/registration number: Provide the registration number and a legible copy of the license/registration.
4. Business name means the name of the laboratory applicant if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application.
5. Business address (location/site of laboratory) means the location where the applicant is providing services, including the street name and number, room or suite number or letter, city, county, state, and five-digit ZIP code. A post office box or commercial box is **not** acceptable.
6. Business telephone number means the primary business telephone number used at the applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is **not** acceptable as the business telephone number.
7. Fax number means the facsimile number used at the business address.
8. E-mail address means the address to which electronic communications may be sent.
9. Pay-to name means the name of the person or business to which payment should be issued by the CHDP Program for CHDP services provided by the laboratory. The pay-to name may be the legal name indicated in number 1, or another person or business chosen by the applicant. **NOTE:** See number 1.
10. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the Laboratory Applicant. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363. If the business is a Sole Proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN, if applicable.
11. The pay-to address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and five-digit ZIP code.
12. Indicate the type of business that applies to your business structure. Provide the names of the principal owners.
13. Enter the name(s) of the director(s) of the laboratory and the address where contact can be made.

14. Provide the current CLIA certificate number and attach a legible copy of the certificate to the application.
15. Enter the expiration date of the CLIA certificate.
16. Enter the number of testing sites to which the CLIA certificate applies.
17. Mark the appropriate box indicating whether or not this lab is located in a licensed acute care hospital.
18. Print the first name, middle initial, and last name of the Laboratory Director.
19. Laboratory Director signature means the first name, middle name, and last name of the Laboratory Director. An original signature ***IN BLUE INK ONLY*** is required. Indicate the date the application is signed. NOTE: Laboratory Director signature on the CHDP Laboratory Provider Program Agreement (DHCS 4503) means the name and signature of the Laboratory Director indicated in number 19.
20. Print the first name, middle initial, and last name of the Laboratory Owner.
21. Laboratory Owner signature means the first name, middle initial, and last name of the Laboratory Owner. An original signature ***IN BLUE INK ONLY*** is required. Indicate the date the application is signed. NOTE: Laboratory Owner signature on the CHDP Laboratory Provider Program Agreement (DHCS 4503) means the name and signature of the Laboratory Owner indicated in number 21.

Did you remember to enclose (as applicable):

- ☐ The original, signed CHDP Laboratory Provider Program Agreement (DHCS 4503)
- ☐ Copy of FEIN or ITIN verification or social security card, if applicable
- ☐ Copy of Fictitious Business Name Statement/Permit, if applicable
- ☐ Copy of CLIA certificate
- ☐ Copy of laboratory license/registration
- ☐ Other, if applicable

Send completed form to:
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Provider Services Unit
MS 8100
P.O. Box 997413
Sacramento, CA 95899-7413