RENDERING PROVIDER FORM

Mail to: Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 South Vermont Avenue
Los Angeles, CA 90005

Request Type

Submit Date ☐ New ☐ Update License Reporting Unit Effective Date ☐ Terminate ☐ Name Change

General Information

Last Name:

First Name:

Middle Initial: Sex: M F Ethnicity

DMH/NGA Staff Code

FFS Ind Prov No.

SSN (Last 4 only)

Language Code

Select DMH Classcode:
☐ DMH
Prov name:

☐ DHS
Prov name:

☐ Non-Governmental Agency (DMH Contracted)
L.E. #:

L.E. Name:

☐ FFS Individual ☐ FFS Group ☐ FFS Org

Tax Payer ID (FFS only)

Contact & Assigned Location Information

Contact name:

Contact Email:

Contact phone no: ( )

Contact Fax No: ( )

☐ **Add this rendering provider in the service location indicated below: (please use form MH-228A for additional locations)**

☐ **Delete this rendering provider in the service location indicated below.** ☐ **Delete this rendering provider in ALL service locations within the legal entity indicated above.**

DMH/NGA Prov No./Rept Unit

FFS Group/Org Prov No.
(Please enter the provider no. associated to the above taxpayer ID)

Effective Date

Termination Date

Locum Tenum

Intern

Name of Organization:

Service Area

MHSA

Address:

City:

Zip:

Taxonomy and License Information (Required if request type is NEW)

Description:

Taxonomy

Professional License #

Effective Date

Expiration Date

Description:

Taxonomy

Professional License #

Effective Date

Expiration Date

DEA License #

Expiration Date

Medicare Prov No.
(DMH directly-operated only)

PPIN Medicare No.
(DMH directly-operated only)

Expiration Date

NPI

NPI Effective Date

Authorized Manager/Designee Signature:

Print Name:

Date:

CIOB USE ONLY

Rendering Provider IS No:

Ticket #

Date Processed

Processed by: