Medicare Crossover COBA/Provider Not On File Form

Instructions			
Current copies of the following documents must be submitted with this form. *** Completed W-9** *** DHCS Rate Letter** (Skilled Nursing/LTC Only)			
Are you a California State Medi-Cal Approved Provider? ○ **Yes** ○ **No**			
Practice Type (select one)			
○ Individual Practice	○ Group Practice	○ Hospital	
○ Ancillary Provider	○ Skilled Nursing/LTC *DHCS Rate Letter Required	○ Durable Medical Equipment	
Type of Specialty Care Provided:			
Practice Site Information			
Facility, Practice, or individual Provider Name			
Address			
City	State	County	ZIP
Main Office Phone #		FAX	
Contact Name		Title	
Contact Email		Contact Phone #	
Payment Information			
Tax ID #:		Billing NPI #:	
*W-9 Attached? (required): ○ **Yes**	**1099 will be mailed to the address listed on the W-9**		
Pay To Address (If different than above)			
Name			
Address			
City	State	ZIP	
Contact Name		Title	
Direct Telephone	FAX	Contact Email	
Information Verification			
I hereby affirm that the information submitted on these documents are current, correct, and complete to the best of my knowledge. Name (print): _____ Signature: _____ Title: _____ Date: _____			

Complete a W-9 and return it with this form to Providers Relations Fax# 707-639-5503 or click the Submit button to email.

Submit