



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

RENDERING PROVIDER FORM

Request Type

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

General Information

Last Name:

Select DMH Classcode:

First Name:

DMH

Prov name:

Middle Initial: Sex: M F Ethnicity

DHS

Prov name:

DMH/NGA Staff Code

Non-Governmental Agency (DMH Contracted)

L.E. #: 00171

FFS Ind Prov No.

L.E. Name: Our Business

SSN (Last 4 only)

FFS Individual FFS Group FFS Org

Language Code

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 0

Authorized Manager/Designee Signature: **REQUIRED** Print Name: Date:

CIOB USE ONLY

Rendering Provider IS No: Ticket #

Date Processed Processed by: