



Medi-Cal Dental

Medi-Cal Dental Provider Directory/Referral Form

Medi-Cal Dental uses the following form to identify providers who are accepting Medi-Cal patients in their office. This form can be completed to update your status at any time. Providers participating in Medi-Cal Dental are automatically listed in the Provider Directory as accepting new patient referrals unless they complete and submit this form indicating otherwise. Please select ONE of the following:

- ☐ Yes, I am accepting new and existing Medi-Cal patients in my office. Please update my status on the Provider Directory. I understand I may request removal of my name from this list at any time by submitting a copy of this form.
- ☐ No, I am not accepting new Medi-Cal patient referrals at this time. Please do not include my name on your referral list and update the provider directory to indicate “not accepting new patients at this time”.
- ☐ Yes, I am accepting new Medi-Cal patients by DHCS referrals only.

Dental License # _____ Billing NPI # _____

Business Name: _____

Fictitious Name/DBA Name: _____

Office Address: _____

Office Number: _____

Email Address: _____

Name and telephone number of person completing the form: _____

Is your office wheelchair accessible? ☐ Yes ☐ No

Have you completed a Cultural Competency Training? ☐ Yes ☐ No

Do you offer American Sign Language (ASL) or have a skilled medical interpreter who provides ASL interpretation services at your office? ☐ Yes ☐ No

What other languages are spoken in your office? _____

List any dental specialties or services offered in your office (i.e., endodontic, general anesthesia, etc.): _____

What ages of children do you see in this practice? *[Select all that apply]*

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special needs accepted *(Select all that apply)*:

<input type="checkbox"/> No	<input type="checkbox"/> Motor impairment	<input type="checkbox"/> Seizures
<input type="checkbox"/> Mildly challenging behavior	<input type="checkbox"/> Cognitive impairment	

Mail, email, fax, or call Medi-Cal Dental to be added to the referral list.

Mail form to:

Medi-Cal Dental
Attn: Provider
Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609

Email form to:

[Medi-CalDental
EnrollmentDept@gainwellt
echnologies.com](mailto:Medi-CalDentalEnrollmentDept@gainwelltechnologies.com)

Fax form to:

(916) 853-6315

Call Medi-Cal Dental at:

(800) 423-0507
Speak with an agent
to get your questions answered
by phone!

Comments:
