

Denti-Cal Bulletin



VOLUME 21, NUMBER 16 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2005

NO CLAIM ACTIVITY FOR 12 MONTHS

Providers who have had no claim activity (submitting no claims or requesting reimbursement) in a 12-month period shall be deactivated per Welfare and Institutions Code Section 14043.62 which reads as follows:

“The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider’s mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.”

If you have not treated any Medi-Cal patients within a 12-month period your Medi-Cal Dental Program provider number will be deactivated. If you wish to remain an active provider in the Medi-Cal Dental Program, complete the form below and mail to: Post Office Box 15609, Sacramento, CA 95852-0609. If the form is not received by Denti-Cal prior to the end of the 12-month period, your provider number will be deactivated. If your provider number is deactivated, you must reapply for enrollment in the Medi-Cal Dental Program. To request an enrollment package contact Denti-Cal toll free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

Check the boxes that apply to your practice:

☐ AAH (Alameda Alliance Health)

☐ GHPP (Genetically Handicapped Persons Program)

☐ CCS (California Children’s Services)

☐ GMC (Geographic Managed Care)
Plan Name: _____

☐ DMC (Dental Managed Care)
Plan Name: _____

☐ HFP (Healthy Families Program)

☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)

Provider Name

Provider Number

Provider Signature