**Individual Nurse Provider (INP)**

**Application Requirements**

* Legal Name
* NPI#, (Link to apply for a NPI: <https://nppes.cms.hhs.gov/#/> )
* Contact Name and Number
* DCA License Printout
* Insurance Policy Number and Effective Date
* State Issued ID#
* CPR-EXP
* Taxonomy
* Resume (include a breakdown of hours worked, i.e., 40 hours per week x 4 weeks x 12 months = total # hours per year)

Please complete all forms and mail to the address listed below:

Medi-Cal Provider Application (DHCS 6204):

<https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/07enrollment_DHCS6204.pdf>

Medi-Cal Disclosure Statement (DHCS 6207):

<http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/03enrollment_DHCS6207.pdf>

Medi-Cal Provider Agreement (DHCS 6208):

<http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/02enrollment_DHCS6208.pdf>

Department of Health Care Services

Integrated Systems of Care Division

Provider Enrollment Unit

1501 Capitol Avenue, MS 4502

P.O. Box 997437

Sacramento, CA 95899-7437

**DO NOT SEND ANY DOCUMENTS TO THE PROVIDER ENROLLMENT DIVISION**

If you have questions regarding the application requirements,

call 916-552-9105, option 5, then option 2.

Email inquiries can be sent to [WaiveProEnroll@dhcs.ca.gov](mailto:WaiveProEnroll@dhcs.ca.gov).