

**B. Rendering Provider Signature**

9. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, Provider Enrollment Division. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.

Printed legal name of rendering provider (last, first, middle)

Original signature of rendering provider

**ATTACH A LEGIBLE COPY OF RENDERING PROVIDER'S DRIVER'S LICENSE OR STATE-ISSUED ID**

**C. Group Provider Signature**

10. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, Provider Enrollment Division. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates. I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

Printed legal name of person signing this affiliation with authority to legally bind the group listed. Please see instructions under number 10 for who can sign. (last, first, middle)

Adler MD, Joshua S.

Original signature of person signing this affiliation with authority to legally bind the group listed

11. Executed at: \_\_\_\_\_, \_\_\_\_\_, on \_\_\_\_\_  
(City) (State) (Date)

**12. Notary Public:**

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

III. Provider Agreement

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments is true, accurate, and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Care Services (“DHCS”), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider in the Medi-Cal program.

I agree to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, the California Attorney General’s Medi-Cal Fraud Unit (“AG”), and the Secretary of the United States Centers for Medicare and Medicaid Services. I further agree to provide if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program. Applicant/Provider will be reimbursed for reasonable copy costs as determined by DHCS or AG.

I also agree that DHCS and/or AG may make unannounced visits to Applicant/Provider, at any of Applicant’s/Provider’s business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG’s powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

Printed legal name of applicant (Last) (First) (Middle)

Original signature of applicant

Executed at: \_\_\_\_\_, \_\_\_\_\_ on \_\_\_\_\_  
(City) (State) (Date)

**Notary Public:** Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act **ARE NOT REQUIRED** to have this form notarized. If notarization is required, the Certificate of Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.