

MEDI-CAL ELIGIBILITY VERIFICATION ENROLLMENT FORM

Important Note: The following provider information must match what is currently on file with DHS Provider Enrollment Services, or the application will not be processed. *Non-providers* are not required to complete this form but may choose to receive the *Medi-Cal POS Network Interface Specifications* document by contacting the POS/Internet Help Desk at 1-800-427-1295.

Medi-Cal Provider Number _____ **CMC Submitter Number**
(Provider number should be 9 digits in length) (if applicable) _____

Name (full legal) _____

Service Address _____ **Ship-to Address**
(if different) _____

City, State, ZIP _____

County _____

Contact Name _____ **Phone Number** () _____

Note: Request will be mailed via United Parcel Service (UPS). Please note that deliveries cannot be made to a Post Office Box.

Below, please choose the eligibility verification option that you desire. If you elect to use the Automated Eligibility Verification System (AEVS), **NO** action is necessary on your part (i.e., you do not need to return these forms).

OPTIONS (put a check mark "✓" in the appropriate space below):

FREE MEDI-CAL POS DEVICE (TERMINAL):

_____ I have read, signed and attached the *Point of Service (POS) Device Usage Agreement*, the *Medi-Cal Point of Service (POS) Network/Internet Agreement* and the *Medi-Cal Eligibility Verification Enrollment Form*. I understand and agree to comply with their terms and conditions. **Note:** The POS Device Option is not available to non-providers.