



Denti-Cal

California Medi-Cal Dental Program

PROVIDER BILLING INTERMEDIARY NOTIFICATION FORM

Provider Name (DBA): _____

Provider Billing ID: _____ Service Office No.: _____

Provider Address: _____

City: _____

State: _____ Zip Code: _____ - _____

Billing Intermediary New Contract Contract Renewal

Contract Begin Date: ____ / ____ / ____ Contract End Date: ____ / ____ / ____

Billing Service Name: _____ Registration No.: _____

Address: _____

City: _____

State: _____ Zip Code: _____ - _____

Telephone: (_____) _____ - _____

Billing Intermediary Contract Termination

Contract Begin Date: ____ / ____ / ____ Contract End Date: ____ / ____ / ____

Billing Service Name: _____ Registration No.: _____

Address: _____

City: _____

State: _____ Zip Code: _____ - _____

Telephone: (_____) _____ - _____

Authorized Provider Original Signature

Date

Return completed form to: Denti-Cal
Provider Enrollment Unit
P.O. Box 15609
Sacramento, CA 95852-0609

If you need assistance, call
Denti-Cal Provider Services
toll-free: 1 (800) 423-0507