



# Denti-Cal

California Medi-Cal Dental Program

## BILLING INTERMEDIARY REGISTRATION FORM

Type of Request:  Initial Registration  Terminate Registration  
 Add Provider (s)  Delete Provider (s)

Billing Service Name: \_\_\_\_\_

Registration No. and Status: \_\_\_\_\_ Current \_\_\_\_\_ Previous

**Mailing Address:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code \_\_\_\_\_ - \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**List Denti-Cal Providers contracted with the Billing Service:**

Provider Name (DBA) Provider ID/Service Office Number	Action: A = Add D = Delete	Action Effective Date
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Authorized Applicant's Name (Please Print) \_\_\_\_\_

Authorized Applicant's Original Signature \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return completed form to: Denti-Cal  
 California Medi-Cal Dental Program  
 P.O. Box 15609  
 Sacramento, CA 95852-0609