

Medi-Cal Managed Care Network Participation Request

California | Anthem Blue Cross | Medi-Cal Managed Care

This form is for community-based adult services (CBAS), doulas, and street medicine providers interested in the Medi-Cal Managed Care (Medi-Cal) network provided by Anthem Blue Cross (Anthem) in California.

Submission of this request form does not guarantee acceptance in the provider network.

Consideration review process

Step 1 — Complete the form below. Please type or print legibly.

Step 2 — Email three documents: this form, IRS *Form W-9*, and Medi-Cal enrollment verification to the appropriate Anthem provider fee-for-service (FFS) for Medi-Cal contracting team:

- Doulas and street medicine providers: SpecialPrograms_Contracting@anthem.com
- CBAS: CAMedicaid_FFSCcontracting@anthem.com

Step 3 — We will review your request to verify that you meet initial participation criteria. You will receive a notice of the outcome with next steps. The review process can take up to two weeks.

Form instructions

To be considered for participation in the network, complete sections A and B below.

Important: FFS for Medi-Cal enrollment is required and must be completed or in process with the California Department of Health Care Services (DHCS) before we can move forward. If you are already approved, please attach evidence of enrollment with this form. If you have recently completed the DHCS screening/enrollment application and are awaiting approval, please include a copy or screenshot of your confirmation that the application was received.

A. Specialty and agreement type

Specialty	<input type="checkbox"/> CBAS <input type="checkbox"/> Doula <input type="checkbox"/> Street medicine provider
Telehealth status	<input type="checkbox"/> Telehealth-only <input type="checkbox"/> Officed-based only <input type="checkbox"/> Both telehealth and in-office
Agreement type	<input type="checkbox"/> Individual <input type="checkbox"/> Group (two or more physicians/practitioners) <input type="checkbox"/> Facility

B. Demographic and contact information

Provider name and title			
Tax ID		Type 1 National Provider Identifier (NPI)	
Medi-Cal/PAVE* enrolled?	<input type="checkbox"/> Yes, effective date: <input type="checkbox"/> Applied, submission date:	Type 2 NPI	
License No.		Specialty	
Service county		CAQH** No.	
Street address		City	
State		ZIP code	
Contact name		Contact email	