ATTACHMENT X

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Interim Director

Curley L. Bonds, M.D.
Chief Medical Officer

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

CONTRACTOR ADDRESS FORM

☐ New
☐ Change of Address

Contractor Name: (Must be the same name in the NPI Registry & Contract)	
DBA: (Must be the same name in the NPI Registry & Contract)	
Contract Number:	
Provider Type:	Group ☐ Individual ☐

All fields below are required

A. ☐ **Mailing Address**
(must attach NPI Registry print out & must match the Provider Business Mailing Address in the NPI Registry)
FFS Provider #:

_____

_____

Telephone No. (_____) _____ **Fax No.** (_____) _____

Provider E-mail:

B. ☐ **Office Service Location** **(listed in Network Providers Directory)** **Accept Referrals:** ☐ **Yes** ☐ **No**
(must match the NPI Registry & Post Office Box is not accepted)
NPI #:

_____

_____

Telephone No. (_____) _____ **Fax No.** (_____) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm :

Service Area: ☐☐☐☐☐☐☐☐☐ **Supervisorial District** ☐☐☐☐☐
1 2 3 4 5 6 7 8 Other 1 2 3 4 5

* Use another sheet for additional Service location on Provider Directory

C. ☐ **Pay To Address**
(must attach W-9 form & must match the address in W-9 form)
http://camisvr.co.la.ca.us/webven/
ECAPS/WebVen Vendor #

_____

_____

Telephone No. (_____) **Fax #:** (_____)

Billing office E-mail:

Please mail the signed form and attachments to Fee-For-Service Section, ATTN: Provider Relations Unit, 510 S. Vermont Ave., 20th Floor, Los Angeles, CA 90020, or by e-mail to: ffs2@dmh.lacounty.gov.

Signature: _____ **Date:** _____

Print Name of Authorized Signer: _____ **Title:** _____

Rev: 1/19/2023 CDAD

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Interim Director

Curley L. Bonds, M.D.
Chief Medical Officer

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

CONTRACTOR ADDRESS FORM

Page 2 of 2 (optional): for additional service locations

Contractor Name: (Must be the same name in the NPI Registry & contract)	
DBA: (Must be the same name in the NPI Registry & contract)	
Contract Number:	
Provider Type:	Group ☐ Individual ☐

☐ **Add** ☐ **Delete Other Service address** **(listed in Network Providers Directory)**

A. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm :

Service Area: ☐☐☐☐☐☐☐☐☐ (1 2 3 4 5 6 7 8 Other) **Supervisorial District** ☐☐☐☐☐ (1 2 3 4 5)

☐ **Add** ☐ **Delete Other Service address** **(listed in Network Providers Directory)**

B. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) _____ **Fax No.** ( ) _____

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm :

Service Area: ☐☐☐☐☐☐☐☐☐ (1 2 3 4 5 6 7 8 Other) **Supervisorial District** ☐☐☐☐☐ (1 2 3 4 5)

☐ **Add** ☐ **Delete Other Service address** **(listed in Network Providers Directory)**

C. Accept Referrals: ☐ **Yes** ☐ **No**

_____

_____

Telephone No. ( ) **Fax No.** ( )

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm :

Service Area: ☐☐☐☐☐☐☐☐☐ (1 2 3 4 5 6 7 8 Other) **Supervisorial District** ☐☐☐☐☐ (1 2 3 4 5)

Please mail the signed form and attachments to Fee-For-Service Section, ATTN: Provider Relations Unit, 510 S. Vermont Ave., 20th Floor, Los Angeles, CA 90020, or by e-mail to: ffs2@dmh.lacounty.gov.

Signature: _____ **Date:** _____

Print Name of Authorized Signer: _____ **Title:** _____