ADDITIONAL INFORMATION CONTRACTOR ADDRESS FORM

PROVIDER NUMBERS are primary locations where the services are provided. Please ensure the correct Provider Numbers are reflected in this Contractor Address Form.

THE PAY TO ADDRESS is the address that will be used FOR REIMBURSEMENT. If you receive reimbursement at more than one location, please indicate in writing by placing a checkmark in the proper Pay To Address, which corresponds with the correct Provider Numbers.

USE THIS FORM IF YOU HAVE A CHANGE OF ADDRESS

Complete the Contractor Address form and return to the address printed on the form. If you have several Provider Numbers, ensure that the correct numbers are included with the Contractor Address Form.

Be extra careful to ensure the correct Provider Numbers are on this form.

DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

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

Rimmi Hundal, M.A.
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/cha/SPA/Main/ServicePlanningAreas.htm :

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

Supervisorial District ☐ ☐ ☐ ☐ ☐
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: Wet-sign **Date:**

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

Rev: 02/11/2025 CDAD

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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 ☐

A. ☐ Add ☐ Delete Other Service address (listed in Network Providers Directory)
Accept Referrals: ☐ Yes ☐ No

Telephone No. _____ Fax No. _____

http://publichealth.lacounty.gov/dhs/SPAMain/ServicePlanningAreas.htm :
Service Area: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ Other Supervisorial District ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

B. ☐ Add ☐ Delete Other Service address (listed in Network Providers Directory)
Accept Referrals: ☐ Yes ☐ No

Telephone No. _____ Fax No. _____

http://publichealth.lacounty.gov/dhs/SPAMain/ServicePlanningAreas.htm :
Service Area: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ Other Supervisorial District ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

C. ☐ Add ☐ Delete Other Service address (listed in Network Providers Directory)
Accept Referrals: ☐ Yes ☐ No

Telephone No. _____ Fax No. _____

http://publichealth.lacounty.gov/dhs/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: _____