

**Department of Health Care Services
SAFETY NET FINANCING DIVISION
GROUND EMERGENCY MEDICAL TRANSPORTATION
POINT OF CONTACT INFORMATION**

Check all boxes that apply:

- New Contact
- Update Contact
- Remove Contact

- Main Contact
- Secondary Contact
- Additional Contact

GEMT Provider Legal Name: _____

GEMT Provider DBA Name: _____

GEMT Program Contact Name: _____

Title: _____

Address: _____

City: _____ State: CA Zip: _____

Phone: _____ Extension: _____

Fax: _____ Email: _____

Fire Chief Name: _____ Fire Chief's Phone Number: _____

NPI #: _____ DHCS Vendor #: GEMT

Please identify your program eligibility authority: City County City & County

Fire Protection District Healthcare District Indian Tribe State

Have acquired/merged with any other entity since January 30, 2010?

Yes No Date Acquired: _____

If so, please provide name(s) of acquitted entity: _____

New/Additional Contact Signature: _____

GEMT Program Coordinator Signature: _____

Print GEMT Coordinator Name: _____ Date: _____

Return to: GEMT@dhcs.ca.gov