MEDI-CAL (M/C) CERTIFICATION TRANSMITTAL

Part A: Provide the following information: **NPI #**

COUNTY SUBMITTING FORM:_____

TYPE OF TRANSACTION *(Check all that apply)*

☐ Activate M/C Activation date:_____ ☐ New Provider ☐ Mode/SF

☐ Terminate M/C Termination date:_____ ☐ All Services ☐ Mode/SF

☐ Re-Cert M/C Recertification Date:_____

If change, indicate one or more types: ☐ **Change:** ☐ Name ☐ Address ☐ Effective date

Date change is effective:_____

PROVIDER NUMBER:_____ PROVIDER NAME:_____

PROVIDER ADDRESS:_____

PROVIDER CITY:_____PROVIDER ZIP CODE: _____

Per the MHP Contract, the M/C activation date cannot be earlier than the latest date of the following dates:
*1) Date the provider requested certification:*_____
*2) Date the site was operational:*_____
*3) Date of the fire clearance:*_____ *(must be within 1 yr. of site visit)*

*In addition, the onsite review must be completed within six months of the activation date. Date of onsite review:*_____
Is this an out-of-county cert/recert? ☐ *Yes* ☐ *No* *If yes, did the host county conduct the onsite visit?* ☐ *Yes* ☐ *No*

Indicate services	Revenue/Procedure Code (CR/DC Mode, Service Function)			
☐ (07) General Hospital	0100 (05/10)	0101 (05/19)	☐ Non-Hospital PHF	H2013 (05/20)
☐ (08) Psych Hosp. Age (< 21)	0100 (05/10)	0101 (05/19)	☐ Crisis Residential	H0018 (05/40)
☐ (09) Psych Hosp. Age (> 64)	0100 (05/10)	0101 (05/19)	☐ Adult Residential	H0019 (05/65)

For Residential – How many beds? _____

Check only one Mode (either 12 or 18): ☐ *(12) Hospital Outpatient* ☐ *(18) Non-Hospital Outpatient*

Indicate services	Procedure Code (CR/DC Mode, Service Function)		(*Check all that apply*)
☐ Crisis Stabilization ER	S9484 (10/20)	☐ Crisis Stabilization UC	S9484 (10/25)
☐ Day TX Intensive Half Day	H2012 (10/81)	☐ Day TX Intensive Full Day	H2012 (10/85)
☐ Day Rehab. Half Day	H2012 (10/91)	☐ Day Rehab. Full Day	H2012 (10/95)
☐ Case Manage/Brokerage	T1017 (15/01)	☐ Therapeutic Behavioral Services (TBS)	H2019 (15/58)
• Intensive Care Coordination (ICC) T1017 (15/07)		☐ Medication Support	H2010 (15/60)
☐ Mental Health Services (MHS)	H2015 (15/30)	☐ Crisis Intervention	H2011 (15/70)
• Intensive Home Based Services (IHBS) H2015 (15/57)			

The above named provider is certified by this agency to participate in the Short-Doyle/Medi-Cal program. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436, the terms of the contract between the MHP and the Department.

_____County Email: _____
Print name of person completing form

_____Phone: (_____)_____Date: _____
Authorized Signature Check below to indicate person signing:

☐ County Mental Health Director or Designee ☐ DHCS Compliance Section

Submit transmittal form to DHCS Compliance Section at *DMHCertification@dhcs.ca.gov*

Part B: DHCS Compliance Section Approval to Transmit Data to DHCS

_____DHCS Compliance Section Date: _____