

MEDI-CAL (M/C) CERTIFICATION AND TRANSMITTAL

Part A: Provide the following information:

COUNTY SUBMITTING FORM: _____ NPI#: _____

TYPE OF TRANSACTION (Check all that apply)

Medi-Cal Activation	Activation date: _____	New Provider	Mode/Service Function
Medi-Cal Termination	Termination date: _____	All Services	Mode/Service Function
Medi-Cal Recertification	Recertification date: _____		

CHANGES? Yes No If yes indicate change and effective date below.

Name	Address	Effective date: _____
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PROVIDER INFORMATION

Provider Name: _____ Provider Number: _____
 Address: _____ City: _____ State: __ Zip Code: _____

MEDI-CAL ACTIVATION DATE

Per the MHP contract, the Medi-Cal activation date cannot be earlier than the latest 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 year of the onsite review): _____
 - 4). Date of the onsite review (The onsite review must be completed within 6 months of the activation date.): _____
 - 5). Is this an out-of-county certification or re-certification? Yes No
- If the answer to question 5 is yes, did the host county conduct the onsite review? Yes No

INPATIENT SERVICES - Revenue/Procedure Code (CR/DC Mode, Service Function)

(07) General Hospital 0100 (05/10) 0101 (05/19)	(08) Psych Hospital Age (< 21) 0100 (05/10) 0101 (05/19)	
(09) Psych Hospital Age (> 64) 0100 (05/10) 0101 (05/19)		
Adult Residential H0019 (05/65)	Crisis Residential H0018 (05/40)	Non-Hospital PHF H2013 (05/20)
Number of Beds (maximum of 16): _____		

Note: All residential certifications & recertifications require submission of the residential license and MUST be 16 beds or less.

OUTPATIENT SERVICES - Revenue/Procedure Code (CR/DC Mode, Service Function)

Mode (Check ONLY one)	(12) Hospital Outpatient	(18) Non-Hospital Outpatient
Case Manage/Brokerage	T1017 (15/01)	Crisis Stabilization ER S9484 (10/20)
- Intensive Care Coordination (ICC)	T1017 (15/07)	Crisis Stabilization UC S9484 (10/25)
Mental Health Services	H2015 (15/30)	Day TX Intensive Half Day H2012 (10/81)
- Intensive Home Based Services (IHBS)	H2015 (15/57)	Day TX Intensive Full Day H2012 (10/85)
Therapeutic Behavioral Services (TBS)	H2019 (15/58)	Day Rehab. Half Day H2012 (10/91)
Medication Support	H2010 (15/60)	Day Rehab. Full Day H2012 (10/95)
Crisis Intervention	H2011 (15/70)	

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 and the terms of the contract between the MHP and the Department.

_____ County Email: _____
 Print name of person completing form

Authorized Signature Signed by: _____ Phone: _____ Date: _____
 County Mental Health Director or Designee DHCS Compliance Section

E-MAIL OR FAX signed and completed form to: EMAIL: DMHCertification@dhcs.ca.gov or by FAX: (916) 440-5497

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

DHCS Compliance Section: _____ Date: _____