

SAMPLE ONLY-DO NOT SUBMIT THIS FORM
MEDI-CAL (M/C) CERTIFICATION TRANSMITTAL

Part A: Provide the following information:

2. NPI # _____

1. COUNTY SUBMITTING FORM: _____

3. 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 NPI # Effective date
 Date change is effective: _____

4. PROVIDER NUMBER: _____ 5. PROVIDER NAME: _____

6. PROVIDER ADDRESS: _____

7. PROVIDER CITY: _____ 8. PROVIDER ZIP CODE: _____

9. 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)

10. 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

11. Indicate services Revenue/Procedure Code (CR/DC Mode, Service Function)

- | | | | | |
|------------------------------------------------------|--------------|--------------|---------------------------------------------|---------------|
| <input type="checkbox"/> (07) General Hospital | 0100 (05/10) | 0101 (05/19) | <input type="checkbox"/> Non-Hospital PHF | H2013 (05/20) |
| <input type="checkbox"/> (08) Psych Hosp. Age (< 21) | 0100 (05/10) | 0101 (05/19) | <input type="checkbox"/> Crisis Residential | H0018 (05/40) |
| <input type="checkbox"/> (09) Psych Hosp. Age (> 64) | 0100 (05/10) | 0101 (05/19) | <input type="checkbox"/> Adult Residential | H0019 (05/65) |
- For Residential – How many beds? _____

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

13. Indicate services Procedure Code (CR/DC Mode, Service Function) (Check all that apply)

- | | | | |
|-------------------------------------------------------|---------------|----------------------------------------------------------------|---------------|
| <input type="checkbox"/> Crisis Stabilization ER | S9484 (10/20) | <input type="checkbox"/> Crisis Stabilization UC | S9484 (10/25) |
| <input type="checkbox"/> Day TX Intensive Half Day | H2012 (10/81) | <input type="checkbox"/> Day TX Intensive Full Day | H2012 (10/85) |
| <input type="checkbox"/> Day Rehab. Half Day | H2012 (10/91) | <input type="checkbox"/> Day Rehab. Full Day | H2012 (10/95) |
| <input type="checkbox"/> Case Manage/Brokerage | T1017 (15/01) | <input type="checkbox"/> Therapeutic Behavioral Services (TBS) | H2019 (15/58) |
| • Intensive Care Coordination (ICC) T1017 (15/07) | | <input type="checkbox"/> Medication Support | H2010 (15/60) |
| <input type="checkbox"/> Mental Health Services (MHS) | H2015 (15/30) | <input type="checkbox"/> Crisis Intervention | H2011 (15/70) |
| • Intensive Home Based Services (IHBS) H2015 (15/57) | | | |

14. 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

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

_____ DHCS Compliance Section

Date: _____