STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

October 31, 2001

Medi-Cal Eligibility Information Letter No.: I 01-14

TO: All County Welfare Directors
All County Medi-Cal Program Specialists/Liaisons

LETTER OF AUTHORIZATION (Over One-Year Letter) MC 180-2 SHARE-OF-COST (SOC) FORM.

This letter is to transmit a copy of form MC 180-2 (8/98). The MC 180-2 is used with the Over One-year Eligibility Letter of Authorization (MC180) to record expenses used to meet a beneficiary's SOC during the time they should have been eligible for Medi-Cal.

The counties should fill out the section with four boxes near the top of the form and the section where the title reads "MEDI-CAL/DENTAL EXPENSES OF FAMILY MEMBERS LISTED BELOW MAY BE USED TO MEET SHARE OF COST." The providers should fill out the rest of the form; instructions for the providers are on the form itself (see enclosed copy).

If you have questions concerning this form, please contact Mr. Craig Yagi of my staff at (916) 657-1182.

Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosure

ELIGIBILITY LETTER OF AUTHORIZATION • SHARE OF COST • RECORD OF HEALTH COST

STATE OF CALIFORNIA • HEALTH AND WELFARE AGENCY • DEPARTMENT OF HEALTH SERVICES

SHARE OF COST • RECORD OF HEALTH COST • MEDI-CAL OR COUNTY MEDICAL SERVICES PROGRAM

MONTH OF ELIGIBILITY MONTH YEAR	SHARE OF COST THE AMOUNT YOU MUST PAY OR OBLIGATE IS $	COUNTY DISTRICT	EW FILE NO.

PLEASE READ THE DECLARATION BELOW:

PROVIDER INSTRUCTIONS AND DECLARATION: EACH SERVICE LISTED BELOW BY ME HAS BEEN PROVIDED BY ME TO THE PERSON LISTED ON THE DATE SPECIFIED. I HEREBY DECLARE THAT I RECEIVED PAYMENT OR WILL SEEK PAYMENT FROM THE PATIENT FOR THE AMOUNT IN THE "*AMOUNT BILLED PATIENT*" COLUMN AND THAT I WILL NOT SEEK OR ACCEPT PAYMENT FROM THE MEDI-CAL PROGRAM FOR THAT AMOUNT. I UNDERSTAND THAT THE AMOUNT REIMBURSED BY INSURANCE, MEDICARE OR ANY OTHER THIRD PARTY FOR THE SERVICE RENDERED CANNOT BE LISTED ON THIS FORM. I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION I HAVE LISTED ON THIS FORM IS TRUE AND CORRECT. I UNDERSTAND THE LETTER OF AUTHORIZATION (MC-180) CANNOT BE ISSUED UNTIL THE SHARE OF COST FOR THIS MONTH IS PAID OR OBLIGATED BY THE BENEFICIARY.

MEDICAL/DENTAL EXPENSES OF FAMILY MEMBERS LISTED BELOW MAY BE USED TO MEET SHARE OF COST.

14 DIGIT COUNTY ID NUMBER (A)					NAME - LAST, FIRST	BIRTHDATE MO. DAY YR.	SEX	OTHER	SOCIAL SECURITY NO.	HIC OR RR NO.
CNTY	AID	7 DIGIT SERIAL NO.	FBU	PERS						

	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
EXAMPLE		0 2 6 7 0 2 3 4 5 6 7 0 5 0	01 / 05 / 88	01 / 05 / 88	90050	OFFICE VISIT
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		AMOUNT BILLED PATIENT	UNREIMBURSED AMOUNT
	Dr. Anne Smith	Dr. Anne Smith	01 / 30 / 88		$ 15.00	$ 15.00
1	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $
2	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $
3	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $
4	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $
5	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $
6	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $
7	PROVIDER MEDI-CAL NUMBER	14 DIGIT COUNTY ID NUMBER (SEE (A) ABOVE)	SERVICE DATES FROM MM / DD / YY	SERVICE DATES TO MM / DD / YY	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE / /		AMOUNT BILLED PATIENT $	UNREIMBURSED AMOUNT $

I AGREE TO ASSUME FULL RESPONSIBILITY FOR THE AMOUNTS LISTED IN THE "AMOUNT BILLED PATIENT" COLUMN.

Signature of Beneficiary: X _____ Date Signed: ___/___/___ TITLE

MC-180-2 (8/98)

PLY ONE TITLE - _____
F.I. COPY

PROOF OF SERVICE

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jet: 1, Copy: Front, Scale: 100%, Type: Manufacturing