FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
STATISTICAL DATA AND CERTIFICATION STATEMENT
MANAGED CARE DIFFERENTIAL RATE REQUEST

Part A

Contact Person:	Date Submitted:
1. FQHC/RHC Name: Clinic A	Telephone Number:
2. FQHC/RHC Address:	Fiscal Year End:
3. FQHC/RHC Number(s)	4. NPI Number(s)

5. Type of Control (Check one)

[ ] Voluntary Nonprofit Corporation: [ ] State [ ] City

[ ] Government: Federal [ ] County [ ] Other

6. FQHC/RHC Owned By

7. Other FQHCs/RHCs, Hospitals, Skilled Nursing Facilities, Home Health Agencies, suppliers or other entities that are owned or related through common ownership or control to the individual or entity listed in item 6:

Provider Name	Location	Clinic or Provider No.

Part B

Certification Statement

Intentional misrepresentation or falsification of any information contained in this request resulting in reimbursement by the Department may be punishable by fine and/or imprisonment under federal and state laws. (42 CFR 1003.102 "Basis for Civil Money Penalties and Assessments", 18 U.S.C 1347 "Health Care Fraud", California Welfare and Institutions Code 14123.25 "Civil Penalties for Fraudulent Claims", and Title 22 of the California Code of Regulations 51485.1 "Civil Money Penalties")

Certification by Officer or Administrator of the Clinic

I, , certify under penalty of perjury as follows:

That I am an official of the subject clinic and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and

Officer or Administrator of FQHC/RHC Print Name: _____ Signature: _____	Title:	Date:

Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.

Mail the original signed Managed Care Differential Rate Request form to:

California Department of Health Care Services
Audits and Investigations, Financial Audits Branch
Audit Review and Analysis Section
1500 Capitol Avenue, MS 2109
P.O. Box 997413
Sacramento, CA 95899-7413

For questions or assistance in completing these forms, you may submit questions to the following email address: Clinics@dhs.ca.gov. You will receive a email response or if you do not have access to email, you may contact Gregory Briscoe at (916) 650-6674.

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
MEDI-CAL MANAGED CARE DIFFERENTIAL RATE REQUEST

Clinic Name: Clinic A **Fiscal Period:** 12/31/2013

Medi-Cal No: FHC12345F (if applicable) **NPI No:** 1234567890

1 **Medi-Cal Managed Care** Plan Name	**Plan A** (Blue Cross)	**Plan B** (Blue Shield)	**Plan C** (Healthnet)	**Plan D** (Blue Cross)	**Plan E** (Blue Cross)	**Total**
2 **Payment Information** [x] Actual [ ] Projected						
A. Managed Care Plan Payments	$ 20,000	$ 60,000	$ 100,000	$ 80,000	$ 20,000	$ 280,000
B. Managed Care Medicare Crossover Payments	$ -	$ 15,000	$ 25,000	$ -	$ 5,000	$ 45,000
Total Managed Care Plan Payments	$ 20,000	$ 75,000	$ 125,000	$ 80,000	$ 25,000	$ 325,000
3 **Visit Information** [x] Actual [ ] Projected						
A. Managed Care Plan Visits	400	1,300	2,500	1500	450	6,150
B. Managed Care Plan - Medicare Crossover	0	160	260	0	50	470
Total Managed Care Visits	400	1,460	2,760	1,500	500	6,620

FEDERALLY QUALIFIED HEALTH CENTER / RURAL HEALTH CLINIC
MEDI-CAL MANAGED CARE DIFFERENTIAL RATE REQUEST

Clinic Name: _____ **Fiscal Period:** _____

Medi-Cal No: _____ **NPI No:** _____

1 **Medi-Cal Managed Care**	**Plan F**	**Plan G**	**Plan H**	**Plan I**	**Plan J**	**Total**
Plan Name	( )	( )	( )	( )	( )	
2 Payment Information [ ] Actual [ ] Projected						
A. Managed Care Plan Payments	$ -		$ -	$ -	$ -	$ -
B. Managed Care Medicare Crossover Payments	$ -		$ -	$ -	$ -	$ -
Total Managed Care Plan Payments	$ -		$ -	$ -	$ -	$ -
3 Visit Information [ ] Actual [ ] Projected						
A. Managed Care Plan Visits	0		0	0	0	0
B. Managed Care Plan - Medicare Crossover	0		0	0	0	0
Total Managed Care Visits	0		0	0	0	0

CALCULATION OF DIFFERENTIAL BILLING RATE (CODE 18)

Clinic Name: Clinic A

Provider No: 1234567890

Fiscal Period: 31-Dec

	Plan A	Plan B	Plan C	Plan D	Plan E	Totals
1) Managed Care Payments Received:	$ 20,000	$ 75,000	$ 125,000	$ 80,000	$ 25,000	$ 325,000
2) Clinic Visits Provided to Mgd. Care Beneficiaries	400	1,460	2,760	1,500	500	6,620
3) Average Amount Received Per Visit (Line 1 / Line 3)	$50.00	$51.37	$45.29	$53.33	$50.00	$49.09
4) Current Medi-Cal Cost Based Interim Rate in EDS	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	N/A
5) Gross Differential By Plan (Line 4 - Line 3)	$75.00	$73.63	$79.71	$71.67	$75.00	N/A
6) Ratio of Mgd. Care Payments by Plan to Total (Line 1 Plan A / Line 1 Total)	6.1538%	23.0769%	38.4615%	24.6154%	7.6923%	100.0000%
Weighted Average Differential (Line 6 x Line 5)	$ 4.62	$ 16.99	$ 30.66	$ 17.64	$ 5.77	$ 75.67 (Z)

(Z)= The differential rate to be paid on interim basis.

CALCULATION OF DIFFERENTIAL BILLING RATE (CODE 18)

Clinic Name: _____ **Fiscal Period:** _____

Provider No: _____

	Plan F	Plan G	Plan H	Plan I	Plan J	Totals
1) Managed Care Payments Received:						$ 325,000
2) Clinic Visits Provided to Mgd. Care Benies						6,620
3) Average Amount Received Per Visit (Line 1 / Line 3)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	N/A
4) Current Medi-Cal Cost Based Interim Rate in EDS				$ -	$ -	N/A
5) Gross Differential By Plan (Line 4 - Line 3)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	N/A
6) Ratio of Mgd. Care Payments by Plan to Total (Line 1 Plan A / Line 1 Total)	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	100.0000%
Weighted Average Differential (Line 6 x Line 5)	0	0	0	0	0	$ 75.67 (Z)

(Z)= The differential rate to be paid on interim basis.

CALCULATION OF DIFFERENTIAL BILLING RATE (CODE 18)

Clinic Name: _____ **Fiscal Period:** _____

Provider No: _____

	Plan K #REF!	Plan L #REF!	Plan M #REF!	Plan N #REF!	Plan O #REF!	Totals
1) Managed Care Payments Received:	$ -	$ -	$ -	$ -	$ -	$ 325,000
2) Clinic Visits Provided to Mgd. Care Benies	-	-	-	-	-	-
3) Average Amount Received Per Visit (Line 1 / Line 3)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	N/A
4) Current Medi-Cal Cost Based Interim Rate in EDS	$ -	$ -	$ -	$ -	$ -	N/A
5) Gross Differential By Plan (Line 4 - Line 3)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	N/A
6) Ratio of Mgd. Care Payments by Plan to Total (Line 1 Plan A / Line 1 Total)	0	0	0	0	0	N/A
Weighted Average Differential (Line 6 x Line 5)	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0! (Z)

(Z)= The differential rate to be paid on interim basis.

FEDERALLY QUALIFIED HEALTH CENTER/RURAL HEALTH CLINIC MEDICARE ADVANTAGE PLAN RATE REQUEST

STATISTICAL DATA AND CERTIFICATION STATEMENT

Part A

1. Contract Start Date:	Date Submitted:	Fiscal Year End:
2. Contact Person:		Contact Telephone Number:
3. FQHC/RHC Name and Address		Contact Fax Number:
4. FQHC/RHC Number(s)		Contact Email Address:

5. Type of Control (Check one)

[ ] Voluntary Nonprofit Corporation: [ ] State [ ] City

[ ] Government: Federal [ ] County [ ] Other

6. FQHC/RHC Owned By

7. Other FQHCs/RHCs, Hospitals, Skilled Nursing Facilities, Home Health Agencies, suppliers or other entities that are owned or related through common ownership or control to the individual or entity listed in item 6:

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Officer or Administrator of FQHC	Title:	Date:
Print Name: _____ Signature: _____		

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Sacramento, CA 95899-7413

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DEPARTMENT OF HEALTH CARE SERVICES
FQHC/RHC MEDICARE ADVANTAGE PLAN(S) INFORMATION REQUEST

Clinic Name: Clinic A **Fiscal Period:** December 31, 2013

NPI No: 1234567890

Please Provide Plan Name	**Plan A**	**Plan B**	**Plan C**	**Plan D**	**Plan E**	**Total**
Payment Information						
A. Payments Received from Medicare Advantage Plan(s)	$10,000	$5,000				$15,000
Visit Information						
A. Medicare Advantage Plan Visits	150	50				200