Department of Health Care Services
Children's Medical Services Network (CMS Net)
Provider Electronic Data Interchange (PEDI)
Access Activation, Modification, Deactivation Request
Attachment B

This form is to be used by providers and health plans to request access to requests for service/service authorization information in PEDI. This request will result in the assignment of a user identification (ID) and password. The form is also to be used to request modification or deactivation of a user ID.

User Identification Information			
Select One	Staff Person Name (Last, First) and Email	Position Title	Telephone Number
☒ Add ☐ Modify ☐ Delete	Example: Jones,Connie cjones@community.org	Patient Account Representative	(415) 999-9999
☐ Add ☐ Modify ☐ Delete			
☐ Add ☐ Modify ☐ Delete			
☐ Add ☐ Modify ☐ Delete			
☐ Add ☐ Modify ☐ Delete			
☐ Add ☐ Modify ☐ Delete			

Name of Provider/Plan:			
Name of PEDI Liaison:		Liaison Telephone Phone:	
Title:		Liaison FAX Phone:	
Liaison E-Mail Address:			
Street Address:			
City:		State:	
Zip:			

Questions? **Contact the DHCS CMS Net Help Desk at (916) 327-2378 or (866) 684-8449**

Return Form to: PEDI Liaison
Department of Health Care Services
Systems of Care Division, MS 8106
P.O. Box 997413
Sacramento, CA 95899-7413

or Fax: (916) 440-5346

Department of Health Care Services
Children's Medical Services Network (CMS Net)
Provider Electronic Data Interchange (PEDI)
CONFIDENTIALITY OATH

Attachment D

As a condition of obtaining access to information concerning procedure or other data and records utilized/maintained by the State Department of Health Services, I agree not to divulge any information obtained in the course of my assigned duties to unauthorized person, and I agree not to publish or otherwise make public any information regarding person(s) enrolled in the California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP) such that the persons who received such services are identifiable.

Access to such data shall be limited to state and federal personnel who require the information in the performance of their duties, and to others such as providers and health care plans as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

Name of Provider/Plan: _____

Printed name of staff	Staff signature	Date