TATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

)EPARTMENT OF HEALTH SERVICES
14/744 P STREET
'CRAMENTO, CA 95814

May 31, 1985

TO: All County Welfare Directors
County Administrative Officers

Letter No.: 85- 42

RECORD OF HEALTH CARE COSTS - SHARE OF COST FORM (MC 177) REVISIONS

The purpose of this letter is to inform you of the revisions that have been made to the Record of Health Care Costs -- Share of Cost (SOC) forms MC 177S-M and MC 177SA-M (Attachment I). The MC 177s have been revised to accommodate the new automated share of cost claims process being implemented July 1, 1985 by Computer Sciences Corporation (CSC).

Background:

Currently, the SOC MC 177s are designed to list health care services rendered by a provider to beneficiaries with a SOC. The MC 177 is subsequently forwarded to the Department for certification and Medi-Cal card issuance. When a provider submits a claim to CSC for payment of services provided a SOC beneficiary, CSC forwards the claim to the Department's Benefit Review Unit (BRU). At that time, BRU staff compare the MC 177 against the claim form to determine what portion of the billed amount was used to meet the SOC. If services listed on the MC 177 match the services listed on the claim, the amount of SOC paid or obligated toward that service is deducted from the billed amount. Claim forms are designed to record services by line item. The current MC 177s are designed to indicate service. For example, if a beneficiary received three prescriptions, the MC 177 would indicate "Prescriptions" in the service description box. When the provider submitted the claim, each of the three prescriptions would be listed as a separate "line item" .

In order to automate the SOC claims process, it is essential that the MC 177 be designed to record "line item" entries.

New Revisions

The following MC 177 form revisions have been made in order to facilitate the new automated share of cost claims process.

- The MC 177s will have a shaded area located in the upper left hand corner which will be utilized by CSC. Counties may not print in this area.
- The MC 177s will have a box titled "SOC Control Number For CSC Use Only". Counties may not print in this area.

- A box titled "Replacement MC 177" has been added to indicate if an MC 177 is a replacement. This box must be checked if the SOC amount for a specific month has been reduced but not to zero. If the SOC amount has been reduced to zero, counties must follow the procedures described in Article 12 C of the Medi-Cal Eligibility Manual.

- The eligibility information (i.e., month and year, SOC amount, Retro Eligibility, etc.) have been relocated to the center of the MC 177.

- The State Number box will include a space for the county code, this must be filled in for each eligible beneficiary (e.g., 14-24-9999999-0-01).

- A separate box has been added to indicate that dental services were provided. If the provider checks the box, Denti-Cal staff will receive a copy of the MC 177 for claims processing.

- The "Billed Medi-Cal" box has been deleted since CSC has no need for this information.

- As is currently done, if the county certifies that a beneficiary has paid or obligated his/her SOC amount, the county can use the box labeled "For State Use Only" for entering the certification date.

- The MC 177s will be available in pinfed format, for those counties with an automated MC 177 process and in non-pinfed format, for those counties without an automated MC 177 process.

- The revised MC 177s will have two parts. Part A which contains all of the pertinent beneficiary information, and Part B which will allow additional line item entries. Part B is to be issued to the beneficiary if all of the line items on Part A have been used and additional services must be listed to meet the SOC.

- The MC 177s will contain an original and three copies. The original and the second copy must always be submitted to the Department for processing. The third copy will remain in the beneficiary file at the county. The fourth copy will remain with the beneficiary for information purposes only.

An initial three month supply of the revised MC 177s (pinfed format for automated counties and non-pinfed format for non-automated counties) will be delivered to each county by CSC in early June 1985. Those counties that administer the County Medical Services Program (CMSP) will also receive an initial three months supply of the CMSP 177. Thereafter, county forms coordinators are to request the MC 177s and CMSP 177s directly from the Department of Health Services, Warehouse, via the Department of Health Services 2031, Form Order.

On May 10, 1985 the Department sent a supply of MC 177 pinfed forms to those counties with an automated MC 177 print process. A call was made on May 15, 1985 explaining that the spacing on the test forms was incorrect but would be corrected on the final forms (pinfed and non-pinfed). The following adjustments must be made when setting up the print programs used to produce the MC 177s and CMSP 177s:

- Reduce the name field by three spaces on the right-hand side.
- The subsequent fields will be moved by three spaces to the left.
- The HIC/RR number will be expanded by three spaces. (See example below)

MEDICAL/DENTAL EXPENSES OF FAMILY MEMBERS LISTED BELOW MAY BE USED TO MEET SHARE COST.													
STATE NUMBER					NAME — LAST, FIRST	B	A	BIRTHDATE			SEX	OTHER COV. CODE	SOCIAL SECURITY NO.	HIC OR RR NO.
CNTY	AID	7 DIGIT SERIAL NO.	FBU	PERS				MO.	DAY	YR				

If you have questions regarding the revisions to the MC 177, please call Dahlia Curry of my staff at (916) 322-2715.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants
MEDS Coordinators
County EDP Coordinators

Expiration Date: December 1985

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REA

SOC CONTROL NUMBER • FOR CSC USE ONLY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

MC 177-SA-M
PART A

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY RECORD OF HEALTH COST—SHARE OF COST

ONLY THOSE MEDICAL/DENTAL EXPENSES INCURRED IN THIS MONTH MAY BE LISTED ON THIS FORM	SHARE OF COST THE AMOUNT YOU MUST PAY OR OBLIGATE IS	REPLACEMENT MC-177 YES NO	RETRO	PAGE	OF	COUNTY DISTRICT	COUNTY USE
MONTH YEAR	$						

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

STATE NUMBER AID	STATE NUMBER 7 DIGIT SERIAL NO.	STATE NUMBER FBU	STATE NUMBER PERS	NAME — LAST, FIRST	B	A	BIRTHDATE MO. DAY YR.	SEX	OTHER COV CODE	SOCIAL SECURITY NO.	HIC OR RR NO.

NTAL SERVICES
DED
YES ☐ NO

DECLARATION OF PROVIDER: EACH SERVICE LISTED BELOW BY ME HAS BEEN PROVIDED BY ME TO THE PERSON LISTED ON THE DATE SPECIFIED. I, THE SIGNED PROVIDER, HEREBY DECLARE THAT I RECEIVED PAYMENT OR WILL SEEK PAYMENT FROM THE PATIENT FOR THE AMOUNT SHOWN IN THE *"BILLED PATIENT"* COLUMN AND THAT I WILL NOT ACCEPT PAYMENT FROM THE MEDI-CAL PROGRAM FOR THAT AMOUNT. I ALSO UNDERSTAND AND AGREE THAT I MAY SEEK PAYMENT FROM THE MEDI-CAL PROGRAM FOR THE COSTS OF MY SERVICES IN EXCESS OF THE AMOUNT BILLED TO THE PATIENT, UP TO THE MEDI-CAL REIMBURSEMENT RATE. I UNDERSTAND THAT THE AMOUNT TO BE REIMBURSED BY INSURANCE OR ANY OTHER THIRD PARTY, INCLUDING MEDICARE, FOR THE SERVICE RENDERED CANNOT BE LISTED ON THIS FORM. I AM AWARE THAT FINANCIAL INFORMATION ON THIS FORM MAY BE SUBJECT TO SCRUTINY BY THE INTERNAL REVENUE SERVICE AND OR STATE FRANCHISE TAX BOARD. I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

PLEASE READ THE INSTRUCTIONS ON THE BACK BEFORE COMPLETING.

ROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
ROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		SERVICE DESCRIPTION	TOTAL BILL
IOVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILL PATIENT
IOVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		SERVICE DESCRIPTION	TOTAL BILL
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READ THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM. I AGREE TO ME FULL LEGAL RESPONSIBILITY FOR THE AMOUNTS LISTED IN THE "BILLED PATIENT" MN.

URE OF APPLICANT DATE SIGNED

SA-M (4)

FOR STATE USE ONLY

DATE CERTIFICATION MO. DAY YR.	REPLACE
REVIEWED BY	TRANS.

DO NOT MARK IN THIS AREA

FOR DENTI-CAL USE ONLY
CORRESPONDENCE CONTROL NUMBER

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

RECORD OF HEALTH COST—SHARE OF COST

MC 177-SA-M

ONLY THOSE MEDICAL/DENTAL EXPENSES INCURRED IN THIS MONTH MAY BE LISTED ON THIS FORM MONTH YEAR	SHARE OF COST THE AMOUNT YOU MUST PAY OR OBLIGATE IS $	REPLACEMENT MC-177 YES NO	RETRO	PAGE OF	COUNTY DISTRICT	COUNTY USE

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

STATE NUMBER				NAME — LAST, FIRST	B	A	BIRTHDATE			SEX	OTHER COV CODE	SOCIAL SECURITY NO.	HIC OR RR NO
AID	7 DIGIT SERIAL NO.	FBU	PERS				MO.	DAY	YR.				

-NTAL SERVICES
DED
YES NO

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ROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)		DATE / /	SERVICE DESCRIPTION	TOTAL BILL $
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JMN.

TURE OF APPLICANT   / / DATE SIGNED

FOR STATE USE ONLY

DATE CERTIFICATION MO. DAY YR.	REPLACE
REVIEWED BY	TRANS

[redacted]

SA M (4)

DENTI-CAL COPY

SOC CONTROL NUMBER • FOR CSC USE ONLY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

MC 177-SA-M
PART A

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY RECORD OF HEALTH COST—SHARE OF COST

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MONTH YEAR	$			OF		

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STATE NUMBER AID	STATE NUMBER 7 DIGIT SERIAL NO.	FBU	PERS	NAME -- LAST, FIRST	B	A	BIRTHDATE MO. DAY YR.	SEX	OTHER COV CODE	SOCIAL SECURITY NO.	HIC OR RR NO

...NTAL SERVICES
...IDED
☐ YES ☐ NO

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...TURE OF APPLICANT DATE SIGNED

...SA-M (4) COUNTY COPY

FOR STATE USE ONLY

DATE CERTIFICATION MO. DAY YR.	REPLACE
REVIEWED BY	TRANS.

DO NOT MARK IN THIS AREA

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DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM
MC 177-SA-M
PART A

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...URE OF APPLICANT DATE SIGNED / /

FOR STATE USE ONLY

DATE CERTIFICATION	REPLACE
MO. DAY YR.	
REVIEWED BY	TRANS.

DO NOT MARK IN THIS AREA