DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

March 21, 1989

TO: All County Welfare Directors
      All County Administrative Officers

ERRATA NOTICE -- ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL) NO. 89-15

SUBJECT: DIALYSIS/TPN CASES ADDED TO MEDS BY THE STATE

It has come to our attention that the sample of the State issued Dialysis/TPN Medi-Cal card was not included with the above subject ACWDL. (The sample was actually for pregnancy and postpartum services.) A correct sample of the Dialysis/TPN card is included with this letter.

We apologize for any inconvenience this error may have caused and if you have any questions, please contact your State Medi-Cal Eligibility Data Systems liaison.

                              Sincerely,

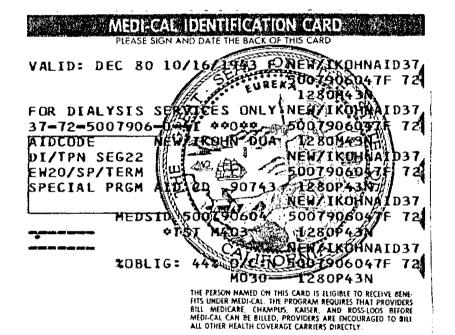   Original signed by

                              Frank S. Martucci, Chief
                              Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
      Medi-Cal Program Consultants

Expiration Date: March 31, 1990

MEDI-CAL IDENTIFICATION CARD

PLEASE SIGN AND DATE THE BACK OF THIS CARD

VALID: DEC 80 10/16/1943 P NEW/IKOHNAID37
500790604 7F 72
1280N43N

FOR DIALYSIS SERVICES ONLY NEW/IKOHNAID37
37-72-5007906-0-1 **0** 500790604 7F 72
1280N43N

AIDCODE NEW/IKOHN-OUA 1280N43N
DI/TPN SEG22 NEW/IKOHNAID37
EW20/SP/TERM 500790604 7F 72
SPECIAL PRGM AIDCD 90743 1280P43N
NEW/IKOHNAID37
MEDSID 500790604 500790604 7F 72
*TST M403 1280P43N
CA NEW/IKOHNAID37
%OBLIG: 44% O/C NO 500790604 7F 72
M030 1280P43N

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENE-
FITS UNDER MEDI-CAL. THE PROGRAM REQUIRES THAT PROVIDERS
BILL MEDICARE, CHAMPUS, KAISER, AND ROSS-LOOS BEFORE
MEDI-CAL CAN BE BILLED, PROVIDERS ARE ENCOURAGED TO BILL
ALL OTHER HEALTH COVERAGE CARRIERS DIRECTLY.

SAMPLE

State Issued Medi-Cal Card
For Dialysis/TPN
Recipients

```
                  |1|                    |2|     |3|
                   |                      |       |
                   |                      |       |
       +-----------------------------------------------------------+
       |           |  MEDI-CAL IDENTIFICATION CARD                 |
       |       PLEASE SIGN AND DATE THE BACK OF THIS CARD           |
       |           |                      |       |                 |
       |       VALID: JAN 89 10/02/1954 F | LASTNAME FIR19          |
  |4|------------   |      SSA# 123456789      2 | 1234567895F 19   |
  |5|------------ PEAK HEALTH PLAN (S.D.)    \ 20189M54N004R1        |
  |6|---------                               \ -------------------- ---|18|
  |7|--------- 19-37-1234567-1-12 **4**                              |
  |8|--------- NAME LINE----------------x                            |
  |9|--------- FIRST ADDRESS LINE-------x                            |
 |10|--------- ADDRESS LINE------------x                             |
 |11|--------- CITY              CA    95814                         |
       |                                                             |
       |              MEDSID 123456789 ------------------------------ ---|19|
 |12|---------           *019 1234 ------------------------------ ---|20|
 |13|---------    ____                 |              |  |          |
 |14|---------    ____  CERT 011589 O/C:N ------------------------- ---|21|
 |15|---------    ____             F015   |           |  |          |
       |                                                             |
       +---------------------------------------------------------- --+
                            |          |        |
                            |          |        |
                           |16|       |17|
```

```
                                        |22a|
                                          |
                                         / \

 |22|----- L A S T N A M E   F I R 1 9
 |23|----- 1 2 3 4 5 6 7 8 9 5 F   1 9
             2 0 1 8 9 M 5 4 N 0 0 4 R 1
             |   \     /   \   /   \   /   \  /
             |    \   /     \ /     \ /     \/
             |     \ /       |       |      |
            |24|   |25| |26| |27|    |29|  |30|

                            |28|
```

```
              |1|                    |2|     |3|
               |                      |       |
               |                      |       |
      +--------------------------------------------------------+
      |        |  MEDI-CAL  IDENTIFICATION  CARD               |
      |   PLEASE SIGN AND DATE THE BACK OF THIS CARD           |
      |         |                      |       |               |
      |    VALID: JAN 89 10/02/1954 F   LASTNAME FIR19         |
  |4|---------  |         SSA# 123456789      2 |1234567895F 19|
  |5|--------- PEAK HEALTH PLAN (S.D.)        \\20189M54N004R1 |
  |6|---------                               \ ------------------ |18|
  |7|--------- 19-30-1234567-1-12 **4**        |
  |8|--------- NAME LINE----------------x      |
  |9|--------- FIRST ADDRESS LINE-------x      |
 |10|--------- ADDRESS LINE------------x       |
 |11|--------- CITY              CA    95814   |
      |        |                               |
      |        |    MEDSID 123456789 ---------------------- |19|
 |12|---------  |        *019 1234 ------------------------ |20|
 |13|---------  ===                             |        | |
 |14|---------  ===  SOC: |0000   O/C:N --------------------- |21|
 |15|--------   ===                 F015        |        | |
      |        |                               |
      +--------------------------------------------------------+
                        |              |
                        |              |
                       |16|          |17|
```

```
                                   |22a|
                                    |
                                    /\

 |22|-----[L|A|S|T|N|A|M|E| |F|I|R|1|9]
 |23|-----[1|2|3|4|5|6|7|8|9|5|F| |1|9]
         [2|0|1|8|9|M|5|4|N|0|0|4|R|1]
          |  \    /  | \ / |  \ / | \
          |   \  /   |  V  |   V  |  \
          |    \/    |     |      |   |
        |24|  |25||26||27|    |29| |30|
                      |28|
```

SCHEMA	LINE	COLUMNS	DESCRIPTION
1	1	2-14	VALID MO/YR OF CARD:
		2-7	'VALID:' FOR CURRENT MONTH CARDS
		2-7 or	'RETRO:' FOR HISTORY MONTH CARDS
		8	SPACE
		9-11	MONTH - ABBREVIATED TO THREE LETTERS
		12	SPACE
		13-14	YEAR - LAST TWO DIGITS OF YEAR
2	1	16-25	BENEFICIARY DATE OF BIRTH
		16-17	BIRTH MONTH - NUMERIC 01-12
		18	CONSTANT '/'
		19-20	BIRTH DAY - NUMERIC 01-31
		21	CONSTANT '/'
		22-25	BIRTH YEAR
3	1	27	BENEFICIARY SEX - M OR F
4	2	8-24	NUMBER TYPE - IN ORDER OF PREFERENCE
			1. SSA# - IF '2' IN MEDICARE INDICATOR
			2. HIC# - IF HIC NUMBER PRESENT
			3. BLANK
5	3	2-27	PILOT PROJECT NAME OR MESSAGE LINE
6	4	2-27	ADDITIONAL DATA LINE

```
7        5        2-25      BENEFICIARY COUNTY ID OR TITLE XVI ID

                            COUNTY ID:
                  2-3         COUNTY CODE
                  4           CONSTANT '-'
                  5-6         AID CODE
                  7           CONSTANT '-'
                  8-14        SERIAL NUMBER
                  15          CONSTANT '-'
                  16          FAMILY BUDGET UNIT (FBU) CODE
                  17          CONSTANT '-'
                  18-19       PERSON NUMBER
                  20          SPACE
                  21-22       CONSTANT '**'
                  23          COUNTY ID CHECK DIGIT
                  24-25       CONSTANT '**'

                            TITLE XVI ID:
                  2-3         COUNTY CODE
                  4           CONSTANT '-'
                  5-6         AID CODE
                  7           CONSTANT '-'
                  8           SDX INDICATOR
                  9           CONSTANT '-'
                  10-18       SOCIAL SECURITY NUMBER
                  19-20       SPACE
                  21-22       CONSTANT '**'
                  23          COUNTY ID CHECK DIGIT
                  24-25       CONSTANT '**'

8        6        2-27      BENEFICIARY NAME

9        7        2-27      FIRST ADDRESS LINE

10       8        2-27      SECOND ADDRESS LINE

11       9        2-27      CITY/STATE/ZIP
                  2-21      CITY/STATE
                  22        SPACE
                  23-27     ZIP CODE

12       12       2-8       FOR STATE USE:    SENSING MARK
                                              (READ/VERIFY LINE)
13       13       2-8       FOR STATE USE:    SENSING MARK
                                              (FEEDER MARK)
14       14       2-8       FOR STATE USE:    SENSING MARK
                                              (ZIP CODE CHANGE)
15       15       2-8       FOR STATE USE:    SENSING MARK
                                              (DEMAND STUFFER)
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16      14      11-21       BENEFICIARY LIABILITY IN ORDER OF PREFERENCE:
                        1.  CERT DATE PRESENT
                11-14           CONSTANT 'CERT'
                15              SPACE
                16-21           CERTIFICATION DATE - MMDDYY

                        2.  LIABILITY AMOUNT PRESENT (ZEROS
                            QUAL FY AS AN AMOUNT)
                11-14           CONSTANT - 'SOC:'
                15-16           SPACES
                ˙7-20           LIABILITY AMOUNT

                        3.  DIALYSIS PERCENT PRESENT
                11-17           CONSTANT - '%OBLIG:'
                18              SPACE
                19-20           PER CENT OF OBLIGATION
                21              CONSTANT - '%'

                            IF NONE OF THESE APPLY, FIELD WILL BE BLANK


17      18      23-26       FOR STATE USE:
                23          HOUR CID RECORD EDITED
                24-26       JULIAN DAY CID RECORD EDITED


18       2      27          MEDICARE STATUS
                            NUMERIC VALUE INDICATES MEDICARE ENTITLEMENT
                            BLANK INDICATES NONENTITLEMENT


19      11      11-26       MEDS IDENTIFICATION NUMBER:
                11-16       CONSTANT - 'MEDSID'
                17          SPACE
                18-26       SOCIAL SECURITY NUMBER


20      12      16-24       COUNTY IDENTIFIER:
                16          CONSTANT - '*'
                17-19       DISTRICT OF REGISTRATION
                20          SPACE
                21-24       MEDS ELIGIBILITY WORKER CODE


21      14      23-27       BENEFICIARY'S OTHER COVERAGE:
                23-26       CONSTANT - 'O/C:'
                27          OTHER COVERAGE CODE


22      TAG1    29-40       BENEFICIARY NAME:
                29-36       LAST NAME
                37          SPACE
                38-40       FIRST NAME


22a     TAG1    41-42       COUNTY CODE

                            FOR REDWOOD HEALTH FOUNDATION (HCP-500):
                41          BENEFICIARY SEX - M OR F
                42          COUNTY ID CHECK DIGIT
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23	TAG2	29-42	BENEFICIARY ID:
		29-37	SOCIAL SECURITY NUMBER
		38	MEDS ID CHECK DIGIT
		39	SEX - M OR F
		40	SPACE
		41-42	AID CODE

			FOR REDWOOD HEALTH FOUNDATION (HCP-500):
		29-42	BENEFICIARY ID:
		29-30	COUNTY CODE
		31-32	AID CODE
		33-39	SERIAL NUMBER
		40	FAMILY BUDGET UNIT (FBU) CODE
		41-42	PERSON NUMBER

24	TAG3	29	MEDICARE STATUS
			NUMERIC VALUE INDICATES MEDICARE ENTITLEMENT
			BLANK INDICATES NONENTITLEMENT

25	TAG3	30-33	VALID MONTH/YEAR OF CARD:
		30-31	MONTH - NUMERIC 01-12
		32-33	YEAR - LAST TWO DIGITS

26	TAG3	34	TYPE OF LABEL:
			FULL SERVICE CARD
			LINES 3 & 6 - 'M'
			LINES 9, 12, 15 - 'P'
			NON-FULL SERVICE CARD
			ALL LINES - 'P'

27	TAG3	35-36	BENEFICIARY YEAR OF BIRTH
			LAST TWO DIGITS OF YEAR

28	TAG3	37	BENEFICIARY'S OTHER COVERAGE

29	TAG3	38-40	PILOT PROJECT OR HEALTH CARE PLAN NUMBER

30	TAG3	41-42	LIMITED OR RESTRICTED SERVICES CODE

```
                                   |1|        |2|      |3|
                                    |          |        |
+------------------------------------------------------------------------------+
|  2*LAST--NAME FIR |2*LAST--NAME FIR|  MEDI-CAL IDENTIFICATION CARD            |
|  5699266321*19 34 |5699266321*19 34|    |        |        |                   |
|  R0389MEDI  *54M4 |R0389MEDI  *54M4| FIRSTNAME  LASTNAME  |      VALID  MAR,1989---|4|
|  A*R1004CRT031589 |A*41004CRT031589| RECIPIENT ID 569-92-6632      DOB 07-08-1978---|5|
|  2*LAST--NAME FIR |2*LAST--NAME FIR| COUNTY ID 19-34-1234567-3-12            SEX M---|6|
|                   |                |                    \-----------------------------|7|
|  5699266321*19 34 |5699266321*19 34| MEDICARE ID 123456789ABC     OTHER COVERAGE A---|8|
|                   |                |                  \-----------------------------|9|
|  R0389POE   *54M4 |R0389POE   *54M4| CERTIFICATION DATE 03/15/89     DISTRICT 001----|10|
|                   |                |                    \-----------------------|11|
|  A*R1004CRT031589 |A*R1004CRT031589|                              CASEWORKER 0009---|12|
|  2*LAST--NAME FIR |2*LAST--NAME FIR| **************************************************** |
|  5699266321*19 34 |5699266321*19 34| **                                              ** |
|  R0389POE   *54M4 |R0389POE   *54M4| **   PEAK HEALTH PLAN (S.D.)                     ** |
|  A*R1004CRT031589 |A*R1004CRT031589| **   FOR DENTAL SERVICES ONLY          -------------|13|
|  2*LAST--NAME FIR |2*LAST--NAME FIR| **                                              ** |
|  5699266321*19 34 |5699266321*19 34| **                                              ** |
|  R0389POE   *54M4 |R0389POE   *54M4| **************************************************** |
|  A*R1004CRT031589 |A*R1004CRT031589|     2N0588344092636                             |
+------------------------------------------------------------------------------+
                                    |
                                   |14|

        |15|            |16|            |17|
         |               |
         |        _____      |
         | |                        | /\
        +--------------------------------------+
        |   2|*|L|A|S|T|-|-|N|A|M|E|  |F||I|R|  |
        |                                      |
        |   5|6|9|9|2|6|6|3|2|1|*|1|9|  |3|4|  |
           |_____| |  \ /   \ /   |
                       |        |   |    |   |
   |18|----------|      |   |    |   |
   |19|---------------------|   |    |   |
   |20|--------------------------|    |   |
   |21|------------------------------|   |
         |                                |
        |R |0|3|8|9|M|E|D|I|  |  |*|7|8|M|4|  |
          |_|_|_____|_|____|   \ /  | |   |
            |      |        |    | |  | |   |
   |22|----   |        |    | |  | |   |
   |23|---------|        |    | |  | |   |
   |24|----------------|      | |  | |   |
   |25|-------------------------|  | |  | |   |
   |26|----------------------------| |  |   |
   |27|------------------------------| |  |
                                        |
        |A|*|R|1|0|0|4|C|R|T|0|3|1|5|8|9|_|
   |28|----|  \ / |__| |_____|
   |29|--------|   |            |
   |30|--------------|          |
   |31|-------------------------|
```

SCHEMA	LINE	DESCRIPTION
1	3	RECIPIENT FIRST NAME
2	3	RECIPIENT LAST NAME

3 4 MEDS IDENTIFICATION NUMBER:
    CONSTANT 'RECIPIENT ID'
    SOCIAL SECURITY NUMBER OR PSEUDO SOCIAL SECURITY NUMBER

4 3 VALID MO/YR OF CARD:
    'VALID' FOR CURRENT MONTH CARDS
    SPACES
    MONTH - ABBREVIATED TO THREE LETTERS
    CONSTANT ','
    YEAR

5 4 RECIPIENT DATE OF BIRTH
    CONSTANT 'DOB'
    SPACE
    BIRTH MONTH - NUMERIC 01-12
    CONSTANT '-'
    BIRTH DAY - NUMERIC 01-31
    CONSTANT '-'
    BIRTH YEAR - NUMERIC, FOUR DIGITS

6 5 RECIPIENT SEX - M OR F

7 5 RECIPIENT COUNTY ID OR TITLE XVI ID
    COUNTY ID:
      COUNTY CODE
      CONSTANT '-'
      AID CODE
      CONSTANT '-'
      SERIAL NUMBER
      CONSTANT '-'
      FAMILY BUDGET UNIT (FBU) CODE
      CONSTANT '-'
      PERSON NUMBER

8 6 RECIPIENT'S OTHER HEALTH INSURANCE COVERAGE:
    CONSTANT - 'OTHER COVERAGE'
    SPACE
    OTHER COVERAGE CODE

9 7 LITERAL - 'SSA#'
   SPACE
   SOCIAL SECURITY NUMBER

   IF MEDICARE ENTITLED:
   LITERAL - 'MEDICARE ID'
   SPACE
   BENEFICIARY NUMBER IN ORDER OF PREFERENCE:
   1. MEDICARE# - IF '2' IN MEDICARE INDICATOR
   2. HIC# - IF HIC NUMBER PRESENT

   IF PSEUDO-SOCIAL SECURITY NUMBER:
   BLANK

10 8 DISTRICT IDENTIFIER:
   CONSTANT - 'DISTRICT'
   SPACE
   DISTRICT OF REGISTRATION

11 7 SHARE OF COST CERTIFICATION DATE (OPTIONAL)
   CONSTANT - 'CERTIFICATION DATE'
   SPACE
   MONTH - NUMERIC 01-12
   CONSTANT '/'
   DAY - NUMERIC 01-31
   CONSTANT '/'
   YEAR - NUMERIC, LAST TWO DIGITS

12 8 WORKER IDENTIFIER:
   CONSTANT - 'CASEWORKER'
   SPACE
   CASE WORKER NUMBER

13 10-14 MESSAGE AREA
   PILOT PROJECT OR HEALTH CARE PLAN NAME, IF APPLICABLE
    -OR-
   LIMITED SERVICES MESSAGE, IF APPLICABLE

14 16 MEDS IMMEDIATE NEED CARD CONTROL NUMBER

15 TAG1 MEDICARE STATUS
   NUMERIC VALUE INDICATES MEDICARE ENTITLEMENT
   BLANK INDICATES NONENTITLEMENT

16 TAG1 RECIPIENT LAST NAME

17 TAG1 RECIPIENT FIRST NAME

18	TAG2	MEDS IDENTIFICATION NUMBER	\ REDWOOD HEALTH
		SOCIAL SECURITY NUMBER	| FOUNDATION (HCP-500):
			| COUNTY CODE
19	TAG2	MEDS IDENTIFICATION NUMBER CHECK DIGIT	| AID CODE
			| CONSTANT - '-'
20	TAG2	RECIPIENT COUNTY CODE	| SERIAL #
			| CONSTANT - '-'
21	TAG2	RECIPIENT AID CODE	| FBU
			/ PERSON #

22   TAG3   RETROACTIVE LITERAL
              IF RETROACTIVE MEDI-CAL - 'R'
              OTHERWISE - BLANK

23   TAG3   VALID MONTH/YEAR OF CARD:
                   MONTH - NUMERIC 01-12
                   YEAR - LAST TWO DIGITS

24   TAG3   TYPE OF LABEL:
                   2 LABELS - 'MEDI'
                   6 LABELS - 'POE '

25   TAG3   RECIPIENT YEAR OF BIRTH
              LAST TWO DIGITS OF YEAR

26   TAG3   RECIPIENT SEX CODE - M OR F

27   TAG3   COUNTY ID CHECK DIGIT

28   TAG3   RECIPIENT OTHER COVERAGE CODE

29   TAG3   LIMITED OR RESTRICTED SERVICES CODE

30   TAG3   PILOT PROJECT OR HEALTH CARE PLAN NUMBER

31   TAG3   SHARE OF COST CERTIFICATION DATE
              CONSTANT 'CRT'
              MONTH - NUMERIC 01-12
              DAY - NUMERIC 01-31
              YEAR - NUMERIC, LAST TWO DIGITS