STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

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

TO: All County Welfare Directors
All County Administrative Officers

June 26, 1989
Letter No.: 89-51

SUBJECT: SHARE OF COST FORMS

This letter is to inform counties that the Part A, Share-of-Cost (SOC) forms, MC 177 S-M (Rev. 6/88), MC 177 SA-M (Rev. 7/89), CMSP 177 S-M (Rev. 11/88), CMSP 177 SA-M (Rev. 11/88) have been revised and will be available in the Department of Health Services (DHS), Warehouse after July 1, 1989. The current Part B, MC 177 and CMSP 177 (Rev. 7/85) forms will continue to be utilized and will not be revised until the excess stock has been depleted in the Warehouse.

SHARE-OF-COST FORMS, PROCESSING AND FUNCTION

Counties provide the CMSP 177 and MC 177 forms to beneficiaries who have a Medi-Cal or CMSP share of cost. The CMSP 177 and MC 177 forms are filled in by the provider of dental/medical services and then returned to the appropriate county department, where they are checked for completeness and to ensure that the share of cost has been met. The form is then sent to the Department of Health Services, Data Systems Branch for certification and Medi-Cal card issuance. In the final processing step, the CMSP 177 and MC 177 forms are then forwarded from DHS to the fiscal intermediaries, Delta Dental and Electronic Data Systems (EDS) for use in adjudicating claims.

THE NEW REVISION DATES AND REVISIONS

New Revision Dates

As of July 1, 1989, counties should begin using Part A, CMSP 177 and MC 177 forms with the following revision dates:

CMSP	177	S-M	(Rev. 11/88);
CMSP	177	SA-M	(Rev. 11/88);
MC	177	S-M	(Rev. 6/88); and
MC	177	SA-M	(Rev. 7/89).

The revision dates on all Part A, CMSP 177 and MC 177 forms prior to the dates listed above should be shredded or destroyed once the counties have received the current forms.

New Revisions

The new revisions on the Part A, CMSP 177 and MC 177 forms are minor and will not effect the automated printing process. The revisions consist of:

1) removing any reference to Computer Science Corporation (CSC) and replacing it with F.I. (Fiscal Intermediary);

2) adding an "example" which has been shaded and completed with beneficiary/service information to act as a guide for the provider when filling out the form;

3) moving blocks "billed patient" and "service description" so that the "billed patient" and "total patient" are placed side by side, rather than directly on top of one another;

4) adding the statement: "You have a right to get a Medi-Cal card the same day you turn this form in if you have a doctor or dentist scheduled or need medicine WITHIN THE NEXT 10 DAYS" to both the MC 177 and CMSP 177 forms. On the MC 177 form only, as it is not applicable to CMSP 177 forms, a second statement has been added: "IMPORTANT: After pregnancy ends, you may be entitled to receive 60 days of no share-of-cost medical benefits related to pregnancy and postpartum services. Notify your eligibility worker as soon as possible after your pregnancy ends;" and

5) reducing the number of service lines from five to three.

CMSP 177 and MC 177 (PART B) - MANUAL CHANGES

Due to the large surplus of Part B, CMSP 177 and MC 177 forms in the DHS Warehouse, the newer Part A, CMSP 177 and MC 177 forms must be used simultaneously with the older Part B, CMSP 177 and MC 177 forms until the surplus has been significantly depleted. The numbering sequence will have to be manually altered on the Part B forms to follow the numbering sequence on the Part A forms. New Part A forms begin with number one and end with number three and Part B forms begin with number six and end with number fifteen. The connecting numbers four and five will not exist on either printed form until the CMSP 177 and MC 177 (Part B) forms are revised; therefore, the Part B numbering should be manually changed by the providers or counties to follow the numbering sequence on Part A by crossing out the six and changing it to a four and the seven to a five, and so on. A Provider Bulletin will be issued notifying providers of these revisions and manual changes.

CMSP 177 and MC 177 (PART A AND B) FORMAT DIFFERENCES

On the CMSP 177 and MC 177 forms there will be minor differences between Part A and Part B (see Attachments 1 and 2). These differences are as follows:

1) the "14-digit state number" on the Part A form is the "patient Medi-Cal I.D. number" on the Part B form;

2) the "billed patient" and "total billed" on Part B are not located side by side as on Part A, but are located on top of one another;

3) the old "CSC" overlay will still be on the Part B form where "F.I." is printed on the Part A form; and

4) the two statements above the signature block on the MC 177 (Part A) and the one statement above the CMSP 177 (Part A) form will not be above the signature block on the MC 177 (Part B) form.

Beneficiaries with a share of cost who are determined to be retroactively Medi-Cal eligible after a CMSP 177 was issued, are not required to have their providers complete a new MC 177. Counties have been instructed to change the CMSP aid code to the appropriate Medi-Cal aid code and subsequently, DHS processes the form as an MC 177. Since the statement relating to possible eligibility for no share of cost postpartum services is not on the CMSP 177, counties are required to inform affected beneficiaries in cases where the CMSP 177 form is used in lieu of the MC 177 form.

If you have any questions regarding the new form changes, revision dates or would like to input suggestions for the future revisions on the CMSP 177 and MC 177 forms please call Maureen McCreary at (916) 322-6455 or Craig Yagi at (916) 322-8702.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: JUNE 26, 1990

DO NOT STAPLE IN BAR AREA

[redacted]

SOC CONTROL NUMBER • FOR F.I. 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 ® 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 OF COST.

14 DIGIT STATE NUMBER Ⓡ CNTY	AID	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.

WHERE DENTAL SERVICES PROVIDED ☐ 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.

	PROVIDER MEDI-CAL NUMBER	14 DIGIT STATE NUMBER (SEE Ⓡ ABOVE)	SERVICE DATES (SEE Ⓢ ABOVE) FROM	TO	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
EXAMPLE	00A000000	19—17—1234567—1—01	01/05/88	01/05/88	90050	OFFICE VISIT
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		BILLED PATIENT	TOTAL BILL
	DR. ANNE SMITH	*Dr. Anne Smith*	01/30/88		$ 15.00	$ 15.00
1	PROVIDER MEDI-CAL NUMBER	14 DIGIT STATE NUMBER (SEE Ⓡ ABOVE)	SERVICE DATES (SEE Ⓢ ABOVE) FROM	TO	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		BILLED PATIENT	TOTAL BILL
			/ /		$	$
2	PROVIDER MEDI-CAL NUMBER	14 DIGIT STATE NUMBER (SEE Ⓡ ABOVE)	SERVICE DATE (SEE Ⓢ ABOVE) FROM	TO	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		BILLED PATIENT	TOTAL BILL
			/ /		$	$
3	PROVIDER MEDI-CAL NUMBER	14 DIGIT STATE NUMBER (SEE Ⓡ ABOVE)	SERVICE DATES (SEE Ⓢ ABOVE) FROM	TO	PROCEDURE/DRUG CODE	SERVICE DESCRIPTION
	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE)	DATE		BILLED PATIENT	TOTAL BILL
			/ /		$	$

"You have a right to get a Medi-Cal card the same day you turn this form in if you have a doctor or dentist scheduled or need medicine WITHIN THE NEXT 10 DAYS."

"IMPORTANT: After pregnancy ends, you may be entitled to receive 60 days of no share-of-cost medical benefits related to pregnancy and postpartum services. Notify your eligibility worker as soon as possible after your pregnancy ends."

My pregnancy ended / or is expected to end on _____

I HAVE READ THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM. I AGREE TO ASSUME FULL LEGAL RESPONSIBILITY FOR THE AMOUNTS LISTED IN THE "BILLED PATIENT" COLUMN.

SIGNATURE OF APPLICANT _____ DATE SIGNED / /

MC 177 SA-M (4) (6/88) 11/89

FOR STATE USE ONLY

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

DO NOT MARK IN THIS AREA

F.I. COPY

DO NOT MARK IN THIS AREA

SOC CONTROL NUMBER • FOR CSC USE ONLY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM
MC 177-S-M

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

PART B

PAGE | OF

INSTRUCTIONS TO PROVIDER

1. Enter only Medical/Dental expenses for family members listed on Part A using their state number.
2. The total of the "Billed Patient" amount must not exceed the "Share Of Cost" amount.
3. If you are not a Medi-Cal provider, enter your license number in the box labeled "Provider Medi-Cal Number".
4. Do not include in the "Billed Patient" or "Total Bill" box the amount to be reimbursed by insurance or any third party, including Medicare, for the service rendered.
5. Complete all items to avoid delay in processing.

ERE DENTAL SERVICES IOVIDED ☐ YES ☐ NO

DECLARATION OF PROVIDER. EACH SERVICE LISTED BELOW BY ME HAS BEEN PROVIDED BY ME TO THE PERSON LISTED ON THE DATE SPECIFIED. THE SIGNED PROVIDER HEREBY DECLARES 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.

	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
6	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
7	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
8	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
9	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
10	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
11	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
12	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
13	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
14	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$
	PROVIDER MEDI-CAL NUMBER	PATIENT MEDI-CAL ID NUMBER	SERVICE DATES FROM	SERVICE DATES TO	PROCEDURE/DRUG CODE	BILLED PATIENT
15	PROVIDER NAME	PROVIDER SIGNATURE (SEE DECLARATION ABOVE) DATE			SERVICE DESCRIPTION	TOTAL BILL
						$

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

SIGNATURE OF APPLICANT

DATE SIGNED

MC 177-S-M (4) 7/85

CSC COPY