

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT PACKET

This enrollment packet consists of an EDI Provider Application/Agreement Form, an Option Selection Form, an ERA Enrollment Form, Title 22 and Forms Reorder Request. An EDI How-To Guide, which provides detailed information on electronic claims submission to Denti-Cal, should accompany this packet.

To submit your Denti-Cal claims electronically:

1. Check with your vendor.

Contact your practice management system vendor for verification that your software includes Denti-Cal's EDI specifications.

2. Complete the attached Application, Option Selection Form and ERA Enrollment Form.

Mail the Application (all four pages), Option Selection Form and, if electronic remittance data is desired, the ERA Enrollment Form to the following address. Delta will confirm your enrollment by letter.

Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609

IMPORTANT: YOUR CLAIMS WILL BE REJECTED IF YOU ARE NOT ENROLLED AS AN EDI PROVIDER PRIOR TO SUBMITTING DENTI-CAL CLAIMS ELECTRONICALLY.

3. Order your EDI supplies directly from the supplier.

If radiographs or attachments are needed to process your claim or TAR, you can submit them conventionally or digitally. If you submit conventional radiographs, you will need to submit an EDI label attached to a specially marked envelope. Use the attached Forms Reorder Request to order a supply of all three types of envelopes (large and small x-ray envelopes, and large mailing envelopes) and one type of self-adhesive EDI label. These supplies are provided at no charge and are printed in red ink to identify them as related to EDI claims. (Note: Most Providers who use the services of a clearinghouse should order laser labels in the preprinted format #DC-018A, format B.)

4. Enter & transmit claims to Denti-Cal.

Your practice management system vendor will advise you how to use your computer and modem to submit your Denti-Cal claims electronically.

5. Retrieve your reports and labels each workday.

Follow your software vendor's instructions. Depending on how your system is linked to Denti-Cal, you may receive your reports and labels through a clearinghouse. Check for reports each workday. *Even if you did not submit any EDI claims the prior workday, you may have NOAs & RTDs waiting to be retrieved, if your system is set up to receive them electronically.*

Note: Check with EDI Support regarding electronic submission of orthodontic services.

**If you have any questions, please call:
Provider Services toll-free at (800) 423-0507
or EDI Support at (916) 853-7373 (email: denti-caledi@delta.org)**

MEDI-CAL DENTAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT (For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, California Department of Health Care Services, hereinafter referred to as the "Department" and:

PROVIDER INFORMATION			
Provider name (full legal)			
Business Name (if applicable)	National Provider Identifier (NPI)		
Provider service address (number, street)	City	State	ZIP Code
Contact person	Email Address		
Contact person address (number, street)	City	State	ZIP Code
Contact telephone number ()	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
BILLER INFORMATION (If other than the provider of service)			
Biller name (full legal)	Biller telephone number ()		
Business Name (if applicable)	Email Address		
Business Address (number, street)	City	State	Zip
Contact Person	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
<i>Full legal name(s) required as well as any assumed Business names(s), address(es), and National Provider Identifier(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."</i>			

1.1 ELECTRONIC DATA INTERCHANGE (EDI) DATA TYPES

This Agreement applies to the following EDI Data Types, when available: (Refer to Provider Service Office Electronic Data Interchange Option Selection Form)

ANSI X 12 837 (Claims/TARs/RTDs/NOAs/Adjustments)
ANSI X 12 276/277 (Claim Status Inquiry/Responses)
ANSI X 12 835 (Claim Payment/Remittance Advice)

1.2 BACKGROUND INFORMATION

The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal Dental electronic Biller.

2.0 DEFINITIONS

The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term "electronic" or "electronically," when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING

The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Denti-Cal Provider Handbook. The Provider hereby acknowledges that he or she has read, and understands the Provider Handbook and its contents, and agrees to read and comply with all Provider Handbook updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION

The Provider agrees by claims submission and certifies under penalty of perjury that all services for which claims are submitted electronically have been personally provided to the patient by the Provider or under his or her direction by another person eligible under the Medi-Cal program to provide such services, and such person(s)

are designated on the claim. The Provider also certifies by claims submission that the services were, to the best of the Provider's knowledge, medically indicated and necessary to the health of the patient. The Provider also certifies that all information submitted electronically is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider/Biller agrees to keep for a minimum period of three years from the date of service an electronic archive of all records necessary to fully disclose the extent of services furnished to the patient. A printed representation of those records shall be produced upon request of the Department during that period of time. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California to the California Department of Health Care Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. The Provider also agrees that dental care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability. The Provider/Biller agrees that when applicable using his or her Medi-Cal Dental Remote ID plus DHCS-issued password when submitting an electronic claim will identify the submitter and shall serve as acceptance of the terms and conditions of the Department's Telecommunications Provider and Biller Application/Agreement (ENBPROV). The Provider/Biller further acknowledges the necessity of maintaining the privacy of the DHCS-issued password and agrees to bear full responsibility for use or misuse of the Medi-Cal Dental Remote ID and password should privacy not be maintained.

3.2 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Regardless of whether Provider employs a Biller, the Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all claim information for payment. This includes usual and customary charges for services rendered. The Provider shall also assume personal responsibility for verification of submitted claims with source documents. The Provider/Biller agrees that no claim shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate suspension of electronic billing and program privileges.

3.3 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its fiscal intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015 and, as from time to time amended. The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information relating to that claim may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds and decertification of the Provider/Biller from participation in the Medi-Cal program and/or electronic billing.

4.0 CHANGES IN ELECTRONIC BILLING STATUS

The Provider/Biller and the Department agree that any changes in Provider/Biller status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5.0 PROVIDER/BILLER REVIEWS

The Provider/Biller agrees that agents of the California Department of Health Care Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider/Biller agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of claims submitted electronically.

5.1 NONEXCLUSIVE REVIEWS

The Provider/Biller agrees that the review set out in paragraph 5.0 above is not exclusive but supplements any other form of audit or review the Provider/Biller may be subject to due to its status as a certified Provider/Biller of services under the Medi-Cal or Medicare programs.

6.0 EFFECTIVE DATE

This agreement shall become effective upon approval of the Department.

6.1 TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Department may, however, terminate the agreement immediately pursuant to paragraph 6.2 upon determination that the Provider/Biller has failed or refused to produce or retain source documents in accordance with federal or state law or this agreement.

6.2 TERMINATION FOR CAUSE

If the Provider/Biller is unable to produce source documents on request pursuant to paragraph 5.0, the Department may terminate this agreement immediately by directing its fiscal intermediary to cease payment of any and all electronic claims submitted by Provider/Biller, including any claims in process on the date of such termination. The Provider/Biller has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Biller may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, California Code of Regulations, Section 51015 as from time to time amended. The Department may demand repayment of claims for which no source documents are produced, and the Provider/Biller shall have a right to appeal of such an overpayment finding to the extent provided by Section 14171 of the Welfare and Institutions Code and regulations promulgated pursuant thereto, and as from time to time amended.

6.3 EFFECT OF TERMINATION AND APPEAL

On termination pursuant to paragraph 6.1 or 6.2, the Provider/Biller may submit hard copy claims.

7.0 AGREEMENT BETWEEN PROVIDER AND BILLER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with Billers to submit Denti-Cal electronic billings shall be in conformance with federal and state law governing electronic claims submission, and shall contain provisions including, but not limited to, the following:

- a. The Provider shall specifically designate the Biller as the agent to the Provider for the purpose of preparation and submission of Medi-Cal Dental claims by Biller. As the Provider's agent, the Biller agrees to comply with all Medi-Cal requirements on record-making and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Sections 14124.2 and 14124 and Title 22, California Code of Regulations, Section 51476. Provider and Biller shall also execute and comply with the provisions of a Business Associate Agreement entered into under the provisions of the HIPAA Privacy Rule, at 45 CFR 164.504(e).
- b. Electronic billing for services rendered to Medi-Cal Dental beneficiaries shall be prepared by the Biller solely from information supplied by the Provider. This information includes usual and customary charges for services rendered. A printed representation of source documents as defined in Title 22, California Code of Regulations, Section 51502.1 shall be kept, including all information transmitted as a claim by the Provider to the Biller electronically, for a period of at least three years from the date of claims submission.
- c. If a department audit is initiated, the Billing Service shall retain all original records described in paragraphs 3.2, 5.0 and 7.0(b) above until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond three years from the date of the service or termination of financial relationship or longer period required by federal or state law.
- d. The parties agree that the Department may accept electronic billings prepared, certified, and submitted by the Biller on behalf of the Provider only as long as the agreement between the Provider and the Biller remains in existence and in effect, including the Business Associate Agreement described in paragraph 7.0(a) above.
- e. Both parties have a duty to notify the Department in writing immediately upon any change in or termination of their agreements.

8.0 DECLARATION OF INTENT

This agreement is not intended as a limitation on the duties of the parties under the Medi-Cal Act, but rather as a means of clarifying those duties as they relate to the Provider/Biller in its capacity as an authorized Provider/Biller for electronic billing.

8.1 PROVIDER TO HOLD STATE OF CALIFORNIA HARMLESS

Provider agrees to hold the State of California harmless for any and all failures to perform by billing services, billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The Provider explicitly agrees that the Provider is assuming any and all risks that accompany electronic billing and that the Provider is not relying upon the evaluation, if any, that the State has made of the electronic billing system, software, or Biller the Provider is using. Furthermore, the Provider acknowledges that if the electronic billing system, software, or Biller contracted with, is or has been listed as available in Denti-Cal bulletins, that such listing was not an endorsement by the State of California, nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

9.0 CONFIDENTIALITY OF RECORD

The Provider/Biller agrees to maintain adequate administrative, technical, and physical safeguards to protect the confidentiality and security of protected health information in accordance with State and Federal statutes and/or regulations, including 45 Code of Federal Regulations Parts 160 and 164. Any breach of security or unlawful disclosure of protected health information shall be reported to the Department within 24 hours of the Provider/Biller's discovery of such breach or disclosure and may be grounds for termination of this Agreement.

10.0 PROVIDER/BILLER OBLIGATIONS

The Provider/Biller will:

- a) Complete and submit to the Medi-Cal Fiscal Intermediary a Medi-Cal Dental Telecommunications Provider and Billing Application/Agreement form for any billers or receivers of any transaction data. The Provider/Biller can be the provider and an outside party (such as a billing service, clearinghouse, or another provider). All billers which are outside parties that have been authorized by a Provider to receive any transaction data must have a Business Associate Agreement in effect between the biller and the Provider, which complies with 45 Code of Federal Regulations, Section 164.504(e).
- (b) Not provide the data supplied under this Agreement to any third party except the applicable agents whom the Provider has authorized to provide billing collection and/or reconciliation services and which have a Business Associate Agreement in effect with the Provider, in compliance with 45 Code of Federal Regulations, Section 164.504(e). The Provider acknowledges that any transaction data is confidential information owned by the State, the Medi-Cal Fiscal Intermediary, and/or applicable providers. This provision shall survive the expiration of this Agreement.
- (c) Upon review of any transaction data, if the Provider/Biller finds the data unreadable or incorrect, they are instructed to contact the Medi-Cal Fiscal Intermediary for resolution. Failure to report any such data inaccuracies shall constitute acceptance thereof.
- (d) The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its Fiscal Intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015, as, from time to time, amended.

PROVIDER SIGNATURE INFORMATION		
Full printed name	Title	
Provider signature (original signature required; <i>DO NOT</i> use black ink)		Date
BILLING SERVICE SIGNATURE INFORMATION (complete only if "Billing Information" is completed on page 1 of 4)		
Full printed name	Title	
Owner or Corporate Office signature (original signature required; <i>DO NOT</i> use black ink)		Date

Return Application/Agreement to: Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609



PROVIDER SERVICE OFFICE ELECTRONIC DATA INTERCHANGE OPTION SELECTION FORM

Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

Provider Name:	National Provider Identifier (NPI):		
Doing Business As Name (DBA):			
Provider Address – Street:	City:	State:	ZIP Code:
Provider Contact Name:	Telephone Number:		
Software/Practice Management System:	Email Address:		

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
 For assistance, contact EDI Support at (916) 853-7373 or by email to denti-caledi@delta.org.

INPUT FROM: Service Office (SO)
 Billing Office (BO)
 Clearinghouse (CH) NAME: _____

You will submit Claims, TARs and Adjustments (ANSI X 12 837).
 Will you also submit NOAs electronically? YES NO
 Will you also submit Claim Status Inquiry (ANSI X 12 276)? YES NO

RETURN OUTPUT OPTIONS when available (shaded options are standard or mandatory):

EDI Document

Electronic RTDs YES NO
 Electronic NOAs YES NO
 Electronic EOB Supplemental Claim Data (If YES: SUMMARY or DETAIL) YES NO
 Would you like to stop receiving Explanations of Benefits (EOBs) by mail? YES NO

**If YES, EDI Support will contact your office to determine the effective date.
 NOTE: Opting not to receive paper EOBs by mail is an option **only** if either the 835 ERA and/or Supplemental EOB file in the Detail format are received.*

Electronic X-Ray/Attachment Labels (If YES: 1-UP or 3-UP) YES
 Report of Documents Awaiting Return Information (CP-0-978-P) YES
 Report of EDI Documents Received (CP-0-973-P) YES
 Claim Status Inquiry Response (ANSI X 12 277) YES NO

_____ Authorized Signature	_____ Submission Date
--------------------------------------	---------------------------------

Return completed form to: Medi-Cal Dental Program
 Provider Enrollment
 P.O. Box 15609
 Sacramento, CA 95852-0609

For Denti-Cal Use Only:	C/H ID:	Remote ID:	P/W:	CV:
--------------------------------	---------	------------	------	-----



ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

PROVIDER INFORMATION			
1. Provider Name:	2. Doing Business As Name (DBA):		
3. Provider Address – Street:	4. City:	5. State/Province:	6. ZIP Code/Postal Code:

PROVIDER IDENTIFIERS INFORMATION	
7. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	8. National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION		
9. Provider Contact Name:	10. Telephone Number:	11. Email Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION
Preference for Aggregation of Remittance Data (Account Number Linkage to Provider Identifier)
12. National Provider Identifier (NPI)
13. Method of Retrieval: The only method of retrieval from Denti-Cal is Secure FTP.

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION
14. Clearinghouse Name:

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION
15. Vendor Name:

16. Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

17. _____ <div style="text-align: center; font-weight: bold; font-size: small;">Authorized Signature</div>	_____ <div style="text-align: center; font-weight: bold; font-size: small;">Submission Date</div>
_____ <div style="text-align: center; font-weight: bold; font-size: small;">Printed Name of Person Submitting Enrollment</div>	

Mail the completed form to: Denti-Cal, Attention: Provider Enrollment Department, P.O. Box 15609, Sacramento, CA 95852-0609.
 To check status, call (916) 853-7373 and ask for EDI Support.

To research and resolve a late or missing v5010 X12 835, please contact Denti-Cal EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org).
 Late or missing is defined as a maximum elapsed time of four business days following the receipt of an associated Electronic Funds Transfer (EFT).

For Denti-Cal Use Only:	Date Entered:		Initials:
--------------------------------	---------------	--	-----------

Instructions for Completing the Electronic Remittance Advice (ERA) Enrollment Form

By submitting this form, the provider is authorizing Denti-Cal to provide remittance data electronically.

The ERA is the v5010 X12 835 transaction. For assistance in completing the Electronic Remittance Advice (ERA) Enrollment form, please contact Denti-Cal EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org). These instructions may also be found in the EDI section on the Denti-Cal website at www.denti-cal.ca.gov.

PROVIDER INFORMATION

1. Enter the provider name
2. If using a doing business as name (DBA) enter the DBA
3. Enter the provider service office street address
4. Enter the service office city
5. Enter the service office state
6. Enter the service office zip code

PROVIDER IDENTIFIERS INFORMATION

7. Depending on how earnings are reported enter the provider tax identification number (TIN) or Employer Identification number (EIN) or Social Security Number (SSN)
8. Enter the provider National Provider Identifier (NPI) for the service office location

PROVIDER CONTACT INFORMATION

9. Enter the contact name
10. Enter the telephone number for the service office
11. Enter the provider email address

ELECTRONIC REMITTANCE ADVICE INFORMATION

12. Enter the provider National Provider Identifier (NPI) for the service office location; must match the preference for ERA payment.
13. Method of retrieval: The only method of retrieval from Denti-Cal is Secure FTP.

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

14. If applicable, enter the name of the provider's Electronic Data Interchange (EDI) clearinghouse

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

15. If applicable, enter the name of the provider's Practice Management System/Software vendor

REASON FOR SUBMISSION

16. Check the ERA action "New Enrollment", "Change Enrollment" or "Cancel Enrollment"

OTHER

17. Sign and date the ERA form; requires the provider's original signature

Mail the completed form to: Denti-Cal
Attention: Provider Enrollment Department
P.O. Box 15609
Sacramento, CA 95852-0609.

To check status, call (916) 853-7373 and ask for EDI Support.

To research and resolve a late or missing v5010 X12 835, please contact Denti-Cal EDI Support at (916) 853-7373 (e-mail: denti-caledi@delta.org). Late or missing is defined as a maximum elapsed time of four business days following the receipt of an associated Electronic Funds Transfer (EFT).

TITLE 22

Section 51502.1 Requirements for Electronic Claims Submission

(a) As used in this section, the following definitions shall apply:

(1) "Biller" includes any employee, officer, agent or director of the entity which will bill on behalf of a provider pursuant to a contractual relationship with the provider which does not include payment to billers on the basis of a percentage of amount billed or collected from Medi-Cal.

(2) "Source Documents" include every document or record on which the provider or the biller relies to submit a claim, as described in Title 22, Section 51476. Source documents shall also include all printed representations of information transmitted as a claim to the biller or the fiscal intermediary, whether transmitted by the provider or biller.

(3) "Provider" shall have the same meaning as in Section 51051 of these regulations.

(4) "Electronic claims submission" means that submission of Medi-Cal claims for service on magnetic tape, computer-to-computer via telephone or other electronic means which are approved by the Director as being compatible with and acceptable for processing by the State claims processing system.

(b) Any enrolled provider may request of the Department authorization to transmit claims to the fiscal intermediary electronically. The Director shall provide written acknowledgement of provider's request for electronic claims submission participation within 30 days of receipt of the request. This acknowledgement shall identify additional information, if any, needed. The Director shall notify the provider in writing of approval or denial within six months of receipt of the request. In the event that the request is denied, the written notice shall specifically set forth the reasons for the denial.

(c) The Director shall authorize such billing unless the Director determines that the requesting provider is ineligible for electronic claims submission. In determining eligibility, the Director shall consider the provider's history of Medi-Cal provider participation, for the three years preceding provider request for participation. A provider shall be determined ineligible for electronic claims submission if during the three years one of the following criteria is met. The provider has:

(1) Been convicted of any felony, crime or misdemeanor involving fraud or abuse of the Medi-Cal, Medicaid or Medicare programs.

(2) Been convicted of any crime involving dishonesty, corruption, theft, fraud, kickbacks, rebates or bribes.

(3) Been found liable or convicted in any civil or criminal legal action involving misuse of electronic communication mechanisms.

(4) Been the subject of any civil or criminal proceedings by any private or public entity administering Medi-Cal, Medicaid or private insurance, which result in one of the following: suspension from the Medi-Cal program in accordance with Title 22, CAC, Section 51458, placement on special claims review in accordance with Section 51460, placement on prior authorization in accordance with Title 22, CAC, Section 51455, recovery of overpayments in excess of 10 percent of total provider annual Medi-Cal payments for the most recent full fiscal year in accordance with Title 22, CAC, Section 51458.1 or the filing of criminal charges for fraudulent billing of the Medi-Cal program in accordance with Sections 14107 of the Welfare and Institutions Code and 72 of the Penal Code.

(5) Failed or refused to provide the Department, its duly authorized agents or agents of other state or federal agencies charged with the review of state or federal expenditures with patient records, source documents or other documentation required by statute or regulation.

(6) Made any false or misleading statement in patient records, substantiation of claims, requests for prior authorization, Departmental application or other documentation in violation of statute or regulation.

(d) Any provider determined by the Director to be eligible for electronic claims submission may employ a biller certified by the Director as eligible to perform such billing. The Director shall provide written acknowledgement of biller request to perform such billing for an eligible provider within 30 days of application date. This acknowledgement shall identify additional information, if any, needed. The Director shall notify biller in writing of approval or denial within six months of request receipt. In the event such a request is denied the written notice shall specify reasons for denial. In determining the eligibility of a biller, the Director shall consider the biller's history of Medi-Cal participation or overall business activities for the three years preceding participation request receipt. A biller shall be determined to be ineligible for electronic claims submission if one of the following criteria is met during the three years preceding receipt of request for participation. The biller has:

(1) Been convicted of any crime involving dishonesty, corruption, fraud, computer fraud, embezzlement, larceny, forgery, falsification of documents, kickbacks, rebates or bribes.

(2) Been found liable or convicted in any civil, criminal or administrative actions involving illegal use of electronic communication mechanisms.

(3) Submitted claims for services not claimed by a provider or for a greater dollar amount than claimed by a provider under the Medi-Cal, Medicaid, Medicare programs or any other health insurance carrier.

(4) Entered an agreement for compensation with any provider based upon percentage or other variable related to the amount billed or collected from the Medi-Cal, Medicaid, or Medicare programs in violation of state or federal law.

(5) Failed or refused to produce source documents for the Department, its duly authorized agents or agents of other state or federal agencies charged with review of state or federal expenditures as provided in statute or regulation.

(6) Failed to demonstrate it employs adequate precautions to protect the confidentiality of Medi-Cal beneficiary records and claims submission methods in accordance with statute or regulation.

(e) The agreement between a provider and a biller shall be in writing and shall be readily retrievable and available on request to the Department or any duly authorized agency for Departmental review to ensure compliance with state and federal standards. Said agreement must in no case contain an agreement for compensation of the biller based on a formula which has as a factor the percentage of the amount billed or collected from the Medi-Cal, Medicaid or Medicare programs in violation of state or federal law.

(f) Any provider or biller eligible for electronic claims submission shall, prior to engaging in any such billing, enter into an agreement with the Department specifying the conditions of participation in such billing methods. This agreement shall be drafted by the Department. The provider and biller shall agree to conditions which shall include, but not be limited to, the following:

(1) Any and all source documents used in documenting, preparing or submitting claims shall be retained in a manner readily retrievable and shall be made available to agents of the Department or any other duly authorized agency on request during normal business hours. Out-of-state providers may be required to produce source documents at a location designated by the Department within the State of California.

(2) All source documents shall be maintained for a period of at least three years from the date received by the FI for payment, as specified by Title 22, CAC, Section 51476.

(3) Source documents, originals or on microfilm/microfiche, shall show the identification of the person or persons who actually rendered the service claimed. All providers shall have on file a printed representation of all information transmitted electronically as a claim by the provider to the biller or the fiscal intermediary. All billers shall produce a printed representation of all information transmitted electronically as a claim by the provider to the biller on demand of the Department or any other authorized agency.

(4) Any instructions between a provider and a biller related to the submission of Medi-Cal claims shall be in writing and available for inspection.

(5) Claims shall not be processed until such time as the Department's fiscal intermediary receives, verifies and posts a Claims Certification Statement and Control Sheet, which shall include all of the following:

(A) A certification of the truth and accuracy of each claim.

(B) The number and total dollar amount of claims submitted.

(C) Such beneficiary identification as the Department may require.

(D) The signature of the provider or the provider's agent.

(6) The Department shall be promptly notified by the provider of any changes in a provider's or biller's status which might affect such person's ability to participate in electronic billing methods.

(7) The provider shall be responsible for ensuring that all remittances and paid claims information are reviewed and that corrections for any overpayments are promptly pursued through the Department's Fiscal Intermediary within the applicable limits of Section 51008(d) of Title 22, CAC.

(8) The provider shall bill those services requiring submission of a MEDI label or other attachment with the claim in accordance with Department billing instructions including instructions regarding structuring the remarks section in a format compatible with electronic data submission.

(g) No provider or potential biller shall submit claims electronically without first securing the approval of the Department for the system to be used for claims submission. In reviewing a proposed billing system, the Department may request submission of a test billing and consider the:

(1) Compatibility with and acceptability for processing by the State claims processing system.

(2) Provider's or potential biller's system for maintaining adequate documentation to support the services, claims and medical necessity thereof.

(h) The test billing and signed provider/biller agreements shall constitute formal request for participation in the electronic claims submission program.

(i) Ongoing approval of the billing system is contingent upon maintenance of the system as approved by the Department under subsection (g). Failure to do so shall be considered grounds for the Department to disapprove the provider or biller for the submission of claims electronically.

(j) Failure or refusal of a provider or a biller to continue to comply with the standards of participation set forth in subsections (c) through (g) shall subject a provider or biller to immediate suspension from participation in the electronic claims submission program. For purposes of applying the standards set forth in those subsections (c) and (d), suspension will occur if one of the events set forth in those subsections has occurred during the three year period prior to the proposed suspension. Notification of the suspension shall be in writing. The provider or biller has the right to appeal the suspension in writing within 30 days of the date of notification. The Department shall review the appeal and any supporting documents in accordance with the time frames and procedures specified in Section 51015(d) of these regulations.

NOTE: Authority cited: Sections 10725, 14040, 14105 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14040, 14100.2, 14107, 14115, 14124.1, 14124.2 and 14170, Welfare and Institutions Code.

(Rev. 6/01 per Register 2001, No. 6; 02/09/2001)

FORMS REORDER REQUEST

To Be Used Only To Reorder Forms For Use In The
CALIFORNIA MEDI-CAL DENTAL PROGRAM

BILLING PROVIDER NAME

NPI/BILLING NUMBER

**FAX FORMS REORDER
REQUEST TO: (877) 401-7534**

MAILING ADDRESS

TELEPHONE NUMBER

OR MAIL TO:

CITY

STATE

ZIP CODE

Denti-Cal Forms Reorder
11155 International Dr.
MS C210
Rancho Cordova, CA 95670

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM FORMS and Envelopes	DC-202 (no carbon required)	DC-209 (continuous pin-fed form)	DC-217 (for laser printers)
	DC-206 (for TAR/Claims)	DC-214A (large X-ray envelopes)	DC-214B (small X-ray envelopes)

Miscellaneous Inventory	DC-003 Claim Inquiry Form (CIF)	DC-007 (CIFs and Correspondence envelopes)	DC-016 HLD Index	DC-054 Justification of Need for Prosthesis
------------------------------------	---	--	----------------------------	--

EDI Supplies

EDI X-Ray Envelopes (Order a supply of all three envelopes)	DC-014E (large X-ray envelopes for EDI)	DC-014F (small X-ray envelopes for EDI)	DC-006C (large mailing envelopes for multiple X-ray envelopes)
--	--	--	--

	Item Number	Description	Select Quantity
EDI Labels (Order <u>one</u> type)	DC-018A	3-up laser (12 labels per sheet). Select label type: A. Blank labels B. Partially preprinted (name & address will be imprinted)*	50 sheets 100 sheets
		DC-018B	1-up continuous labels (4 labels per sheet)
	DC-018C	3-up continuous labels (12 labels per sheet)	250 sheets 500 sheets