

Forms Reorder Request: Medical Services and Allied Health

Page updated: September 2020

This section explains how to complete the *Provider Forms Reorder Request*. Providers who need a *Provider Forms Reorder Request* for either hard copy or electronic billing should contact the Telephone Service Center (TSC) at 1-800-541-5555.

CALIFORNIA MMIS FISCAL INTERMEDIARY		PROVIDER FORMS REORDER REQUEST for ALLIED HEALTH and MEDICAL SERVICES						
FORM NUMBER	TITLE 1	INDICATE QUANTITY DESIRED (X)				OTHER (Indicate Amount)	ENVELOPES (Indicate Amount) (500 per box)	
		100	800	1500	2700			
	(91240-E) Envelopes for Allied Health and Medical Services						2	
50-1	TREATMENT AUTHORIZATION REQUEST (TAR) 4-Part (900 per box)							
50-1C	TREATMENT AUTHORIZATION REQUEST (TAR) 4-Part (Continuous Pin-Fed) (700 per box)							
50-2	TREATMENT AUTHORIZATION REQUEST (TAR) 1-Part (FAX) (2500 per box)							
50-2C	TREATMENT AUTHORIZATION REQUEST (TAR) 1-Part (Continuous Pin-Fed/FAX) (2700 per box)							
60-1	CLAIMS INQUIRY (CIF) 2-Part (1200 per box)					2000	100	
60-1C	CLAIMS INQUIRY (CIF) 2-Part (Continuous Pin-Fed) (1250 per box)							
90-1	APPEAL 2-Part (1200 per box)	X					50	

IF YOU HAVE QUESTIONS REGARDING CHANGE OF ADDRESS, PLEASE CALL 1-800-541-5555.

ORDER ONLY A 2- to 3-MONTH SUPPLY, ALLOWING 2-3 WEEKS FOR DELIVERY.

3

ATTENTION:
Billing Department
General Hospital
1234 Admit Avenue
Sacramento, CA 95862

4

PROVIDER NUMBER
0123456789

Note: Provider number or billing service submitter number must be entered or orders cannot be processed.

CONTACT PERSON: JANE SMITH
PHONE NUMBER: (916) 555-5555

#208 PROPubs 12/18

Figure 1: Sample California MMIS Fiscal Intermediary *Provider Forms Reorder Request for Medical Services and Allied Health*.

Explanation of Form Items

Item	Description
1	Indicate Quantity Desired (X): Mark one of the quantity boxes or indicate “other” amount desired.
2	Envelopes: Indicate number of envelopes requested (500 envelopes per box).
3	Ship To Address: Enter the name and address where the forms are to be shipped. Include an “Attention” line if applicable. <u>Do not</u> use a P.O. Box.
4	Provider Number: The provider number or billing service submitter number <u>must</u> be in this box or the <i>Provider Forms Reorder Request</i> form will be returned.

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.