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## Forms Reorder Request: Long Term Care

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Page updated: December 2023

«This manual section has been retained to provide reference to LTC-related billing instructions for dates of service prior to February 1, 2024. This manual section is not live and does not reflect current billing policy and should not be referenced when billing for dates of service on or after February 1, 2024. For current billing instructions as of February 1, 2024, refer to the appropriate manual section in the [Long Term Care Provider Manual](#).»

This section explains how to complete the *Provider Forms Reorder Request for Long Term Care*. 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 Long Term Care					
FORM NUMBER	TITLE <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">1</span>	INDICATE QUANTITY DESIRED (X)					ENVELOPE Indicate Amount (500 per box) <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">2</span>
		100	700	1400	2400	OTHER (Indicate Amount)	
20-1C	LTC TREATMENT AUTHORIZATION REQUEST (TAR) 4-Part (600 per box)						
25-1C	PAYMENT REQUEST FORM 2-Part (Continuous Pin-Fed) (1400 per box)					2000	100
60-1	CLAIMS INQUIRY (CIF) 2-Part (1200 per box)						
60-1C	CLAIMS INQUIRY (CIF) 2-Part (Continuous Pin-Fed) (1250 per box)						50
90-1	APPEAL 2-Part (1200 per box)						
DHS 6114	RECORD OF NON-COVERED SERVICES 1-Part						
MC-171	NOTIFICATION OF PATIENT ADMISSION, DISCHARGE, DEATH 1-Part (Includes 006A Form)						

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.

SHIP-TO ADDRESS: (MUST BE COMPLETED.) (CANNOT SHIP TO P.O. BOX.) 3

ATTENTION:  
Billing Department  
Shady Oak Convalescent  
1234 Admit Avenue  
Sacramento, CA 95862

PROVIDER NUMBER 4

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

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**Figure 1:** Sample California MMIS Fiscal Intermediary *Provider Forms Reorder Request for Long Term Care.*

## **Explanation of Form Items**

Item	Description
1	<b>Indicate Quantity Desired (X):</b> Mark one of the quantity boxes or indicate “other” amount desired.
2	<b>Envelopes:</b> Indicate number of envelopes requested.
3	<b>Ship To Address:</b> 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	<b>Provider Number:</b> 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.>>

<b>Symbol</b>	<b>Description</b>
<<	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.