Claims Follow-Up

Introduction

Purpose

The purpose of this module is to provide an overview of the options available to providers when following up on claims that have been submitted for payment.

Module Objectives

- Review timeliness standards
- Understand *Remittance Advice Details* (RAD)
- Explain claim follow-up options for the *Claims Inquiry Form* (CIF 60-1), the *Appeal* form (90-1) and the Correspondence Specialist Unit (CSU)
- Review CIF (60-1) and Appeal (90-1) form completion
- Introduce the Electronic Claim Resubmission Process

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

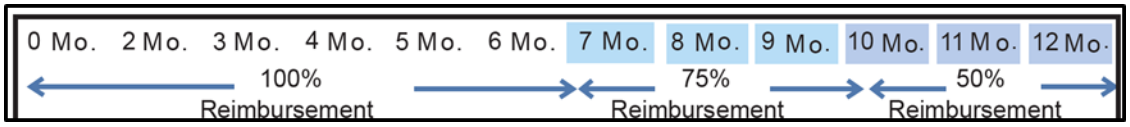
Claim Follow-Up Description

A claim must be received within a specified time frame to process and adjudicate appropriately for payment or denial. The time frames are specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been improperly completed will be denied and providers will be notified via the RAD.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the California Medicaid Management Information System (California MMIS) Fiscal Intermediary within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.



Full Reimbursement Policy

The chart provides the last date that a claim can be filed to meet the six-month submission deadlines for full reimbursement. Providers who submit claims within the six-month billing limit are eligible to receive 100 percent of the Medi-Cal maximum allowable payment for services rendered.

Reimbursement Deadlines

If the Date of Service (DOS) falls within this month:	Then claims must be received by the last day of this month:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Partial Reimbursement Policy

Claims submitted **after** the six-month billing limit and received by the California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

- 7-9 months after the month of service will be remibursed 75% of the payable amount
- 10-12 months after the month of service will be reimbursed 50% of the payable amount
- Over 12 months with no valid delay reason code will be denied

Claim Follow-Up Process

Medi-Cal claims received by the California MMIS Fiscal Intermediary may not process through the California Medicaid Management Information System (CA-MMIS) as providers anticipate; sometimes claims are denied. Providers can obtain CIFs, Appeal forms and envelopes by contacting the Telephone Service Center (TSC) at 1-800-541-5555.

There are a number of reasons why claims do not process correctly. Some examples include:

- Minor information is omitted from the claim.
- Information on the claim is incorrect.

CA-MMIS looks at claims critically in a series of edits and audits. After these edits and audits are completed, the claim is adjudicated or suspended.

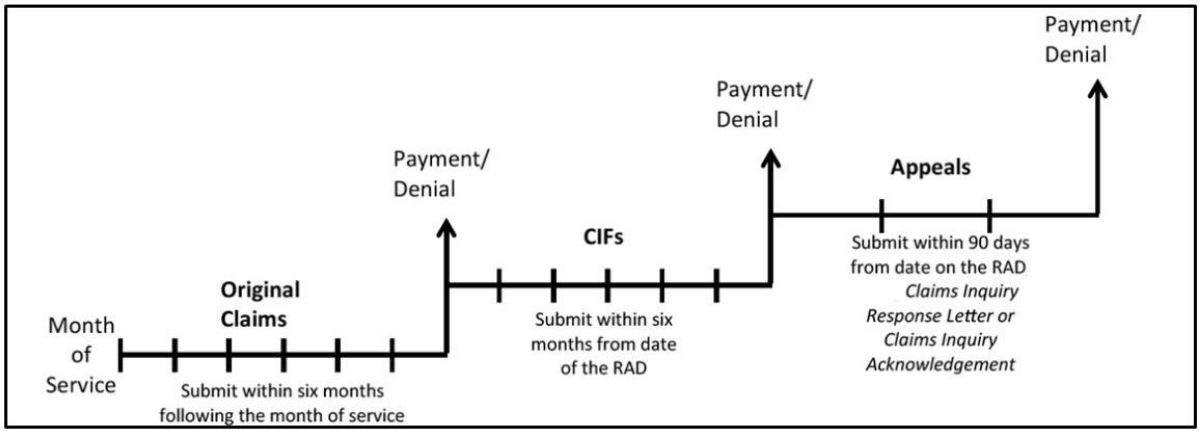
Depending on the reason the claim was denied, the provider can take one of the following follow-up actions:

Table of Provider Follow Up Options when Claim is Denied

If Claim is:	Provider Follow Up Options
Denied	Rebill the claim.
Denied	Submit a *Claims Inquiry Form* (CIF).
Denied	Submit an Appeal form.
Denied	Contact the Correspondence Specialist Unit (CSU).

Timeliness Submission Guidelines

Timeliness submission Guidelines chart.



Remittance Advice Details (RAD) – Financial Reconciliation Statement

RAD Description

The RAD is designed for line-by-line reconciliation of transactions. RADs offer providers a record to help determine which claims are paid, denied or not yet adjudicated. RADs are issued by the State Controller's Office (SCO) and contain reimbursement data of claims being paid relevant to the payment period and a cumulative summary of year-to-date earnings.

If there are no claims being paid, or if a payment is being applied to a negative adjustment or Accounts Receivable (A/R), a *No Payment Advice* will be issued instead of a warrant.

Weekly RADs will appear for Medi-Cal-only claims first, followed by Medicare/Medi-Cal crossover claims in the following sequence: adjustments, approvals, denials, suspensions and A/R transactions.

RAD Access

Providers are able to securely view and download their RAD and a summary sheet called a *Medi-Cal Financial Summary*. The RADs are available on the Medi-Cal Provider Portal website.

Navigating to RADs

1. Navigate to the Medi-Cal Provider Portal. Enter the email address and select **Next**.

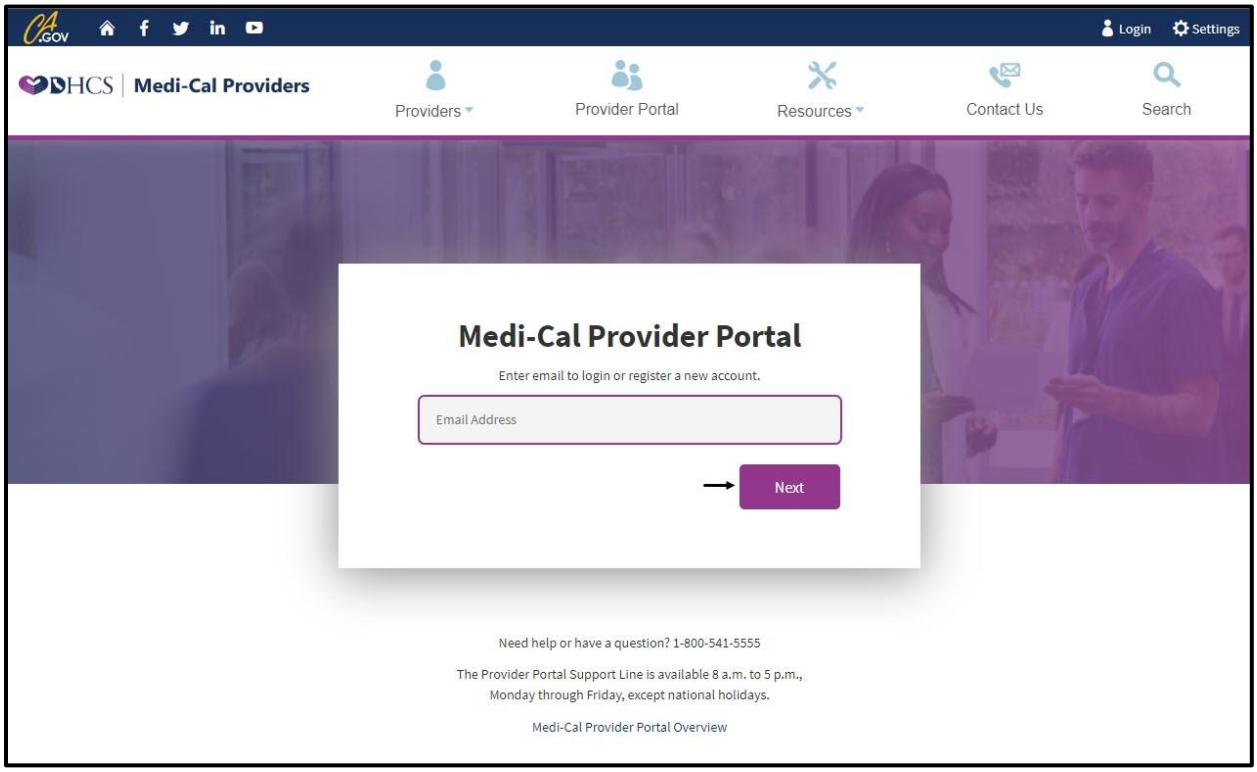


Figure 1.1: The Medi-Cal Provider Portal.

2. On the Login screen, enter the password and select **Log In**.

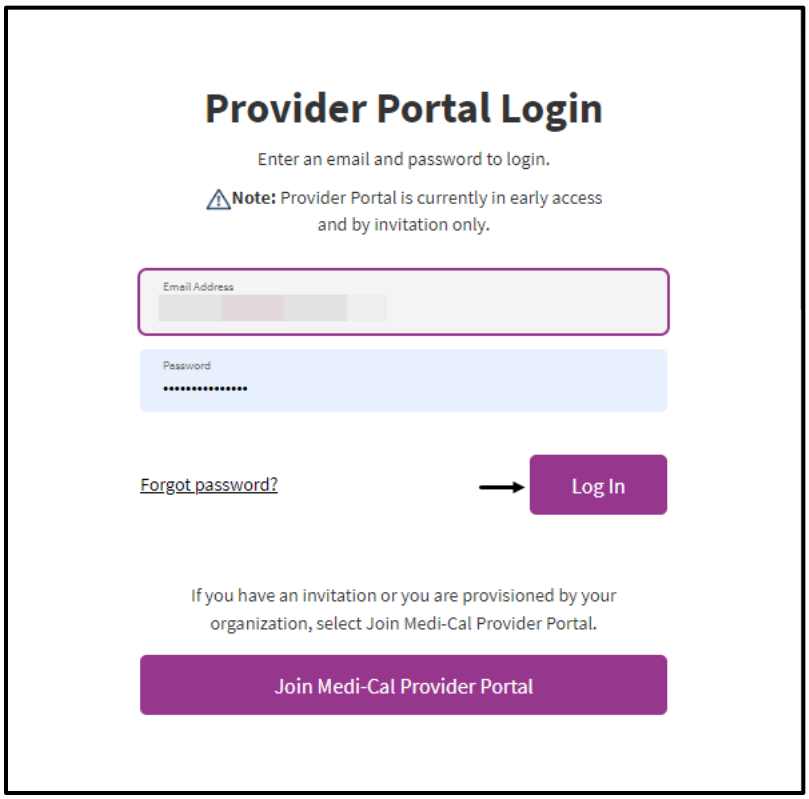


Figure 1.2: Provider Portal login screen.

3. Navigate to the Communication Center and select **Search for Correspondence**.

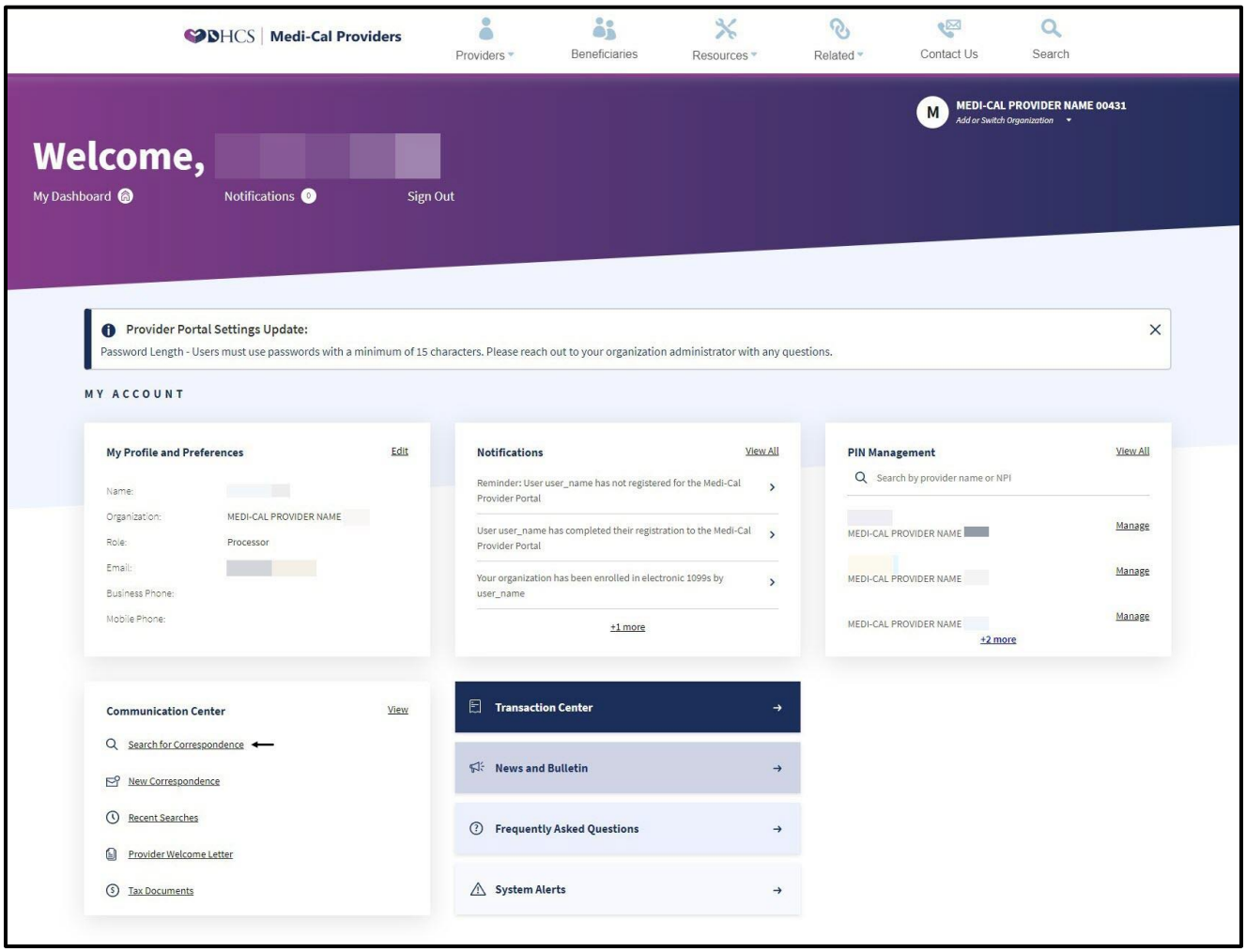


Figure 1.3: Provider Portal homepage.

4. Select the preferred method to receive a one-time passcode and select **Submit.**

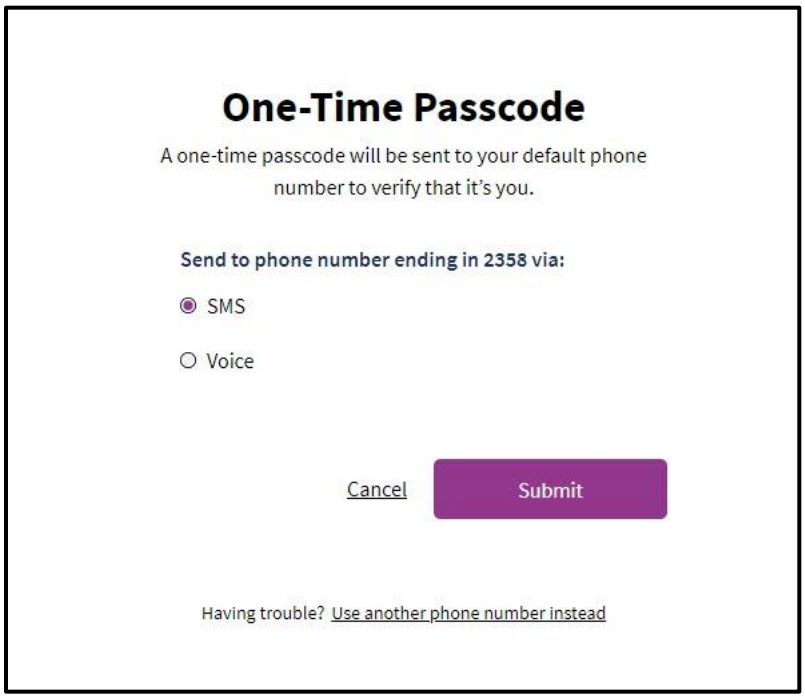


Figure 1.4: One-Time Passcode request.

5. Enter the one-time passcode and select **Next**.

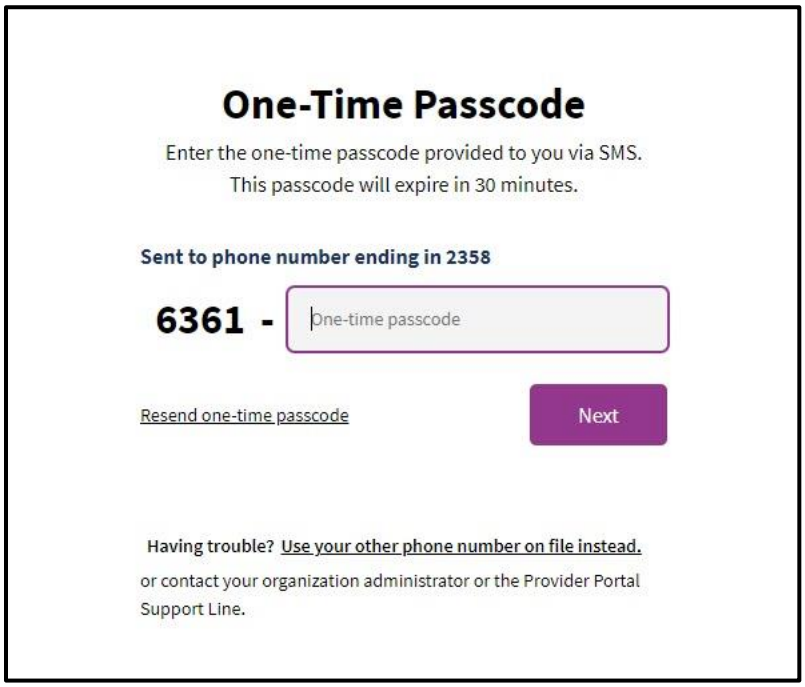


Figure 1.5: One-Time Passcode screen.

6. Select an NPI from the drop-down menu, choose PDF Remittance Advice Detail (RAD) from the Correspondence type drop-down and then enter a date range.

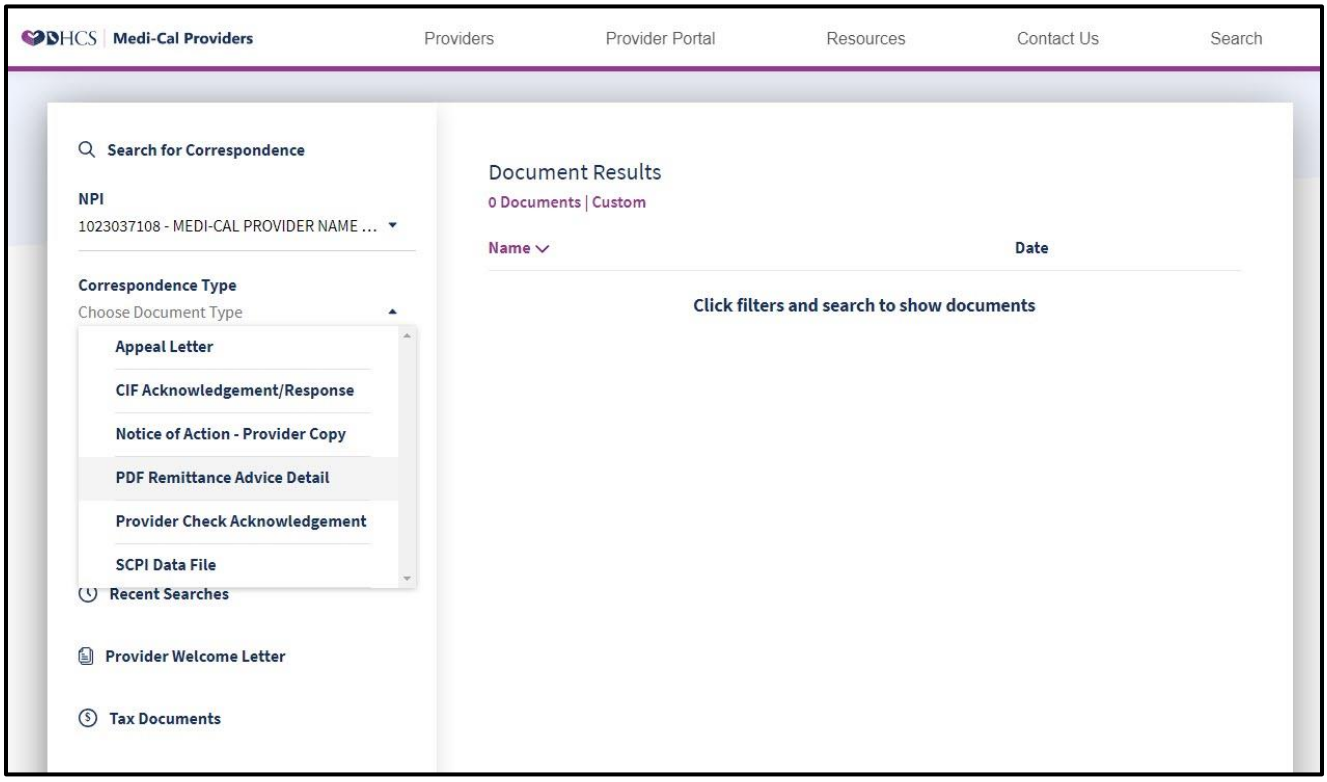


Figure 1.6: Search for Correspondence page.

7. Select the desired RAD, navigate to the vertical ellipse and select the format to download the RAD.

Figure 1.7: Download format options.

PDF RAD Benefits

There are many benefits to accessing RAD and *Medi-Cal Financial Summary* information online:

- The PDF RAD (and embedded financial summary information) is available earlier than paper RADs and financial summaries.
- The PDF RADs and financial summary contains all the information of paper RADs and financial summaries.
- Help California go green by no longer receiving paper RADs.
- Printed versions of the online PDF RADs are adequate to submit as supporting documentation with *Claims Inquiry Forms* (CIFs) and *Appeal* forms.

No provider payments will be made via PDF RADs. PDF RADs are for informational purposes only.

Adjustments

Previously paid claims may be adjusted if an error in payment occurred. An adjustment may be initiated by the provider, the California MMIS Fiscal Intermediary or Department of Health Care Services (DHCS). An adjustment reprocesses a claim with corrected information and appears on the RAD as two lines.

- Line 1 – Shows the new Claim Control Number (CCN) and reflects the correct payment.
- Line 2 – Shows the original CCN and deducts the original payment.

A “void” adjustment appears on the RAD as a single line with a negative (-) amount. A void recovers the original payment without automatically reprocessing the claim. After a void is completed and the claim history is adjusted, providers may submit a new claim. This is a critical step. Sometimes providers void a claim and neglect to submit a new claim, and therefore do not receive payment.

Approvals

Approved claims are line items passing final adjudication. They may be reimbursed as submitted or at reduced amounts according to Medi-Cal program reimbursement specifications. Reduced payments are noted on the RAD with the corresponding RAD code.

Notes:

Denials

Denied claim lines represent claims that are unacceptable for payment due to one of the following conditions:

Claim information cannot be validated by the California MMIS Fiscal Intermediary.

- Billed service is not a program benefit
- Line item fails the edit/audit process

Note: A denied message on the RAD is the only record of a claim denial.

Suspensions

Claims requiring manual review will temporarily suspend, but will usually appear as a payment or denial on the RAD within 30 days. Claims still in suspense after 30 days will appear on the RAD with a “suspend” message code. Providers should not submit Claims Inquiry Forms (CIFs) for claims listed as “suspends” on the most recent RAD.

Notes:

Accounts Receivable (A/R) Transactions

RADs may also reflect Accounts Receivable (A/R) transactions when necessary, either to recover funds from or pay funds to a provider. Claims that appear on the RAD are sorted by recipient name (alphabetical by last name of recipient and date of service). The Accounts Receivable system is used in financial transactions.

- A/R Transaction Types:
  - Recoupment of interim payments.
  - Withholds against payments to providers according to State instructions.
  - Payments to providers according to State instructions.
- Unique Features:
  - A/R transactions are identified in the system by a 10-digit A/R transaction number, such as “1234567890.”
  - Amounts can be either positive (+) or negative (-) figures that correspond to the increase or decrease in the amount of the warrant.
  - A/R transaction RAD codes appear at the bottom of the page in the RAD message column and begin with the number “7.”

Inquiries about A/R transactions should be mailed to the Financial Cash Control Unit (FCCU). Inquires must be submitted hard copy and include the A/R number and a copy of the RAD.

Attn: Financial Cash Control Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

Notes:

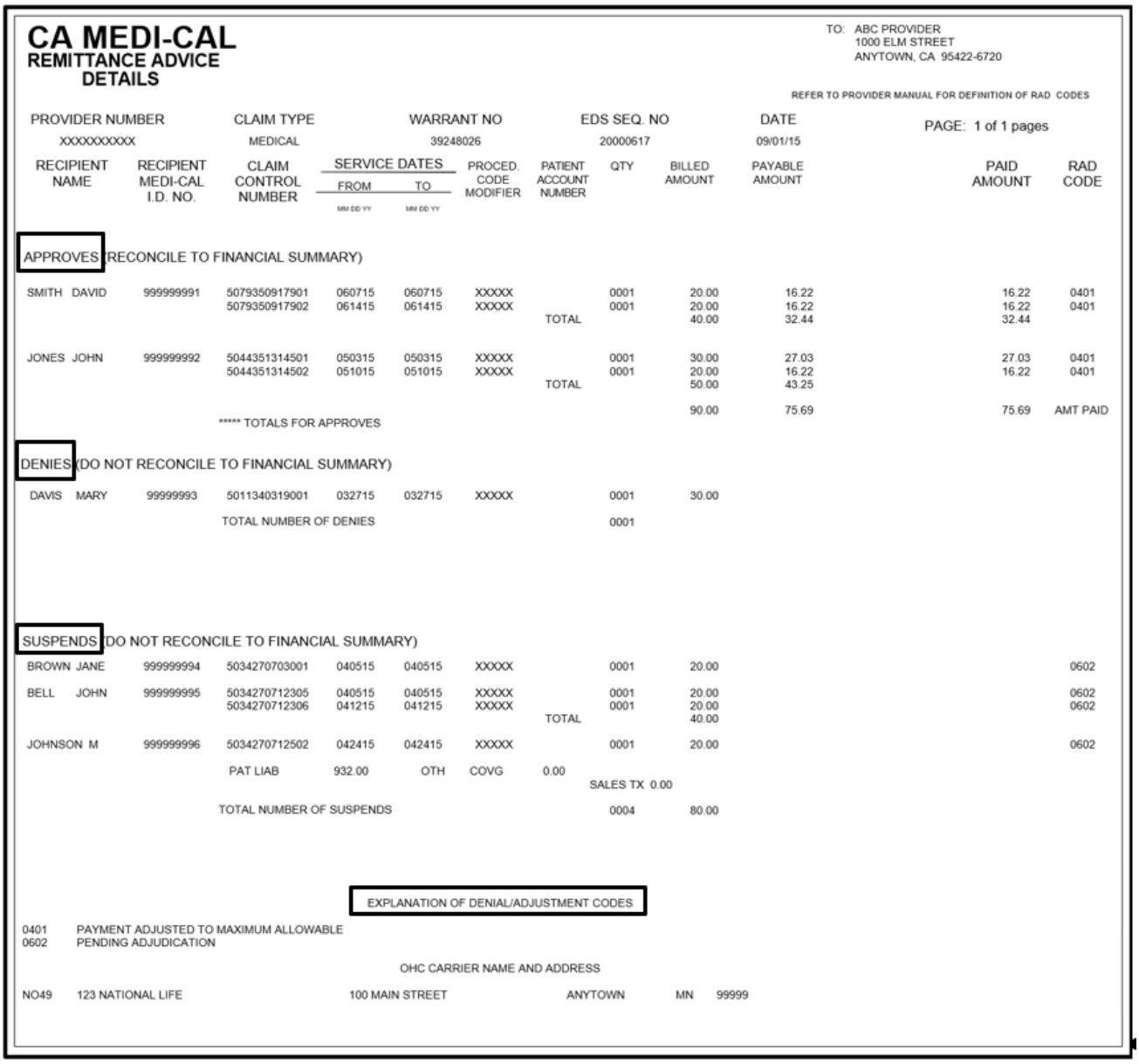
RAD Form Information

- RAD codes appear in the far-right column for each recipient, with a full explanation of the RAD code at the bottom of the RAD
- RADs can include up to a maximum of three denial code messages with some denial codes beginning with a prefix “9” which indicates a free-form error message
- Free-form messages allows the denial message to describe the denial error more accurately
- RAD details will always appear in the same order on a provider’s RAD if applicable in the following order:

- Approves
- Denies
- Suspends
- Explanation of Denials/Adjustment Codes

Remittance Advice Details Form Examples

Sample *Remittance Advice Details* (RAD). Actual size is 8½ x 11 inches.



CA MEDI-CAL
REMITTANCE ADVICE DETAILS

TO: ABC PROVIDER
1000 ELM STREET
ANYTOWN, CA 95422-6720

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

PROVIDER NUMBER	CLAIM TYPE	WARRANT NO	EDS SEQ. NO	DATE	PAGE: 1 of 1 pages
XXXXXXXXXX	MEDICAL	39248026	20000617	09/01/15	

RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	PROCED. CODE MODIFIER	PATIENT ACCOUNT NUMBER	QTY	BILLED AMOUNT	PAYABLE AMOUNT	PAID AMOUNT	RAD CODE
APPROVES (RECONCILE TO FINANCIAL SUMMARY)											
SMITH DAVID	999999991	5079350917901	060715	060715	XXXXX		0001	20.00	16.22	16.22	0401
		5079350917902	061415	061415	XXXXX		0001	20.00	16.22	16.22	0401
						TOTAL		40.00	32.44	32.44	
JONES JOHN	999999992	5044351314501	050315	050315	XXXXX		0001	30.00	27.03	27.03	0401
		5044351314502	051015	051015	XXXXX		0001	20.00	16.22	16.22	0401
						TOTAL		50.00	43.25		
		***** TOTALS FOR APPROVES						90.00	75.69	75.69	AMT PAID
DENIES (DO NOT RECONCILE TO FINANCIAL SUMMARY)											
DAVIS MARY	99999993	5011340319001	032715	032715	XXXXX		0001	30.00			
		TOTAL NUMBER OF DENIES					0001				
SUSPENDS (DO NOT RECONCILE TO FINANCIAL SUMMARY)											
BROWN JANE	999999994	5034270703001	040515	040515	XXXXX		0001	20.00			0602
BELL JOHN	999999995	5034270712305	040515	040515	XXXXX		0001	20.00			0602
		5034270712306	041215	041215	XXXXX		0001	20.00			0602
						TOTAL		40.00			
JOHNSON M	999999996	5034270712502	042415	042415	XXXXX		0001	20.00			0602
		PAT LIAB 932.00		OTH COVG	0.00		SALES TX 0.00				
		TOTAL NUMBER OF SUSPENDS					0004	80.00			

EXPLANATION OF DENIAL/ADJUSTMENT CODES

0401 PAYMENT ADJUSTED TO MAXIMUM ALLOWABLE
0602 PENDING ADJUDICATION

OHC CARRIER NAME AND ADDRESS

NO49 123 NATIONAL LIFE 100 MAIN STREET ANYTOWN MN 99999

Sample Medi-Cal Financial Summary *Remittance Advice Details* (RAD). Actual size is 8½ x 11 inches.

CALIFORNIA **MEDI-CAL FINANCIAL SUMMARY**

PROVIDER NAME	BANK TRANSIT	ACCOUNT NUMBER	ACS SEQUENCE NUMBER
ABC PROVIDER	1234567	100123456	99999979

PROVIDER NUMBER	PAYMENT DATE	PAYMENT NUMBER	PAYMENT AMOUNT	REMITTANCE
10234567890	01/01/2018	000000000	80000.00	ADVICE PAGES

	ALLOWED (+) AMOUNT	OTHER (-) PAYMENT	ADJUSTMENT INFO (-) DEBIT	ADJUSTMENT INFO (+) CREDIT	AMOUNT PAID
1. PRIOR YTD					
2. PAYMENT SUMMARY:					
3. MEDI-CAL ADJUSTMENTS					
4. MEDI-CAL APPROVES	80000.00				80000.00
5. MEDICARE ADJUSTMENTS					
6. MEDICARE APPROVES					
7. SUB-TOTAL					
8. A/R PAYMENTS					
9. A/R APPLIED (-)					
10. NEGATIVE BALANCE CREATED					
11. WARRANT AMOUNT					
12. CALENDAR YR. TO DATE					
13. NON CASH RECONCILIATION ITEMS:					
14. 1099 ADJUSTMENT (INCREASE)					
15. 1099 ADJUSTMENT (DECREASE)					
16. 1099 ADJUSTMENT FOR PERSONAL CHECK REFUND					
17. CHECKS AND RETURNED WARRANTS					
18. ADJUSTED 1099 AMOUNT					
19. 1099 YTD TOTAL					

State of California
DIRECT DEPOSIT ADVICE

NUMBER

Provider Number	Fund No.	Fund Name
01234567890		

MO	DAY	YR
01	01	18

$ DOLLARS 8000 CENTS 00

THIS IS NOT A CHECK

When changing accounts or financial institutions notify the FI immediately. Do not close your old account until you have received your first payment in your new account

Sample *Remittance Advice Details* (RAD). Actual size is 8½ x 11 inches.

CA MEDI-CAL

7171

TO:

Remittance Advice Details

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

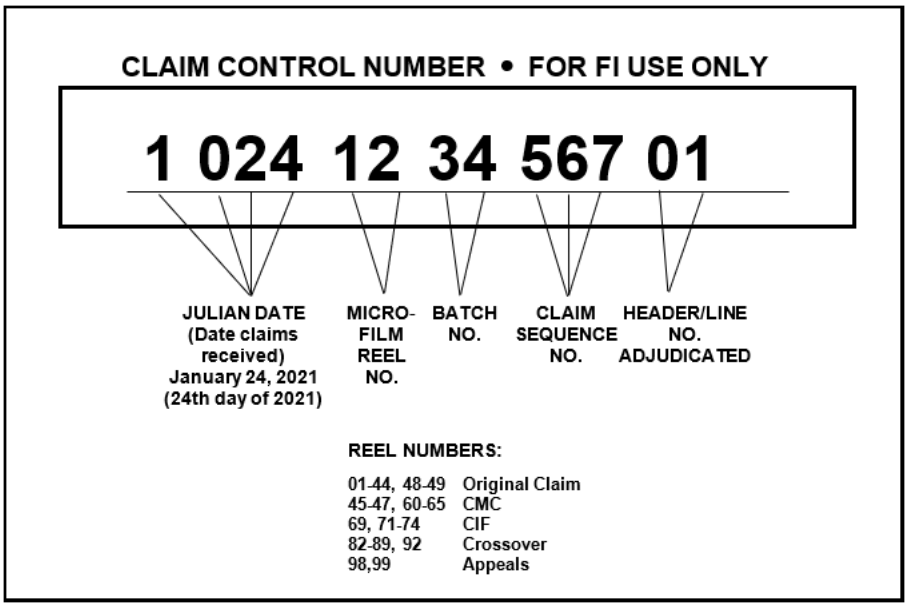
PROVIDER NUMBER	CLAIM TYPE	WARRANT NO.	FI SEQ. NO.	DATE	PAGE:	OF	PAGES
01234567890	,MEDICAL	0000000000	99999979				

RECIPIENT NAME	RECIPIENT MEDI-CAL	CLAIM CONTROL NUMBER	SERVICE DATES FROM MMDDYY	SERVICE DATES TO MMDDYY	PROC. CODE	PATIENT CONTROL NUMBER	QTY	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE
JOHN JONES	0999999991	5079360917901	11/01/18	11/01/18				8000.00	0000	8000.00	1.00	8000.00	

Note: For additional information, refer to the Part 2 provider manual, *Remittance Advice Details (RAD) Examples: Allied Health and Medical Services* section (remit ex amp).

Claim Control Numbers

The Claim Control Number (CCN) is used to identify and track Medi-Cal claims as they move through the claims processing system. The CCN contains the Julian date, which indicates the date a claim was received by the California MMIS Fiscal Intermediary, and is used to monitor timely submission of a claim.



Julian Date Calendar

Table of Julian Dates and their Corresponding Claim Control Numbers

Day Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	N/A	88	119	149	180	210	241	272	302	333	363
30	30	N/A	89	120	150	181	211	242	273	303	334	364
31	31	N/A	90	N/A	151	N/A	212	243	N/A	304	N/A	365

Note: The Claim Control Number is used to identify and track Medi-Cal claims as they move through the claims processing system. This number contains the Julian date, which indicates the date a claim was received by the California MMIS Fiscal Intermediary and is used to monitor timely submission of a claim.

For leap years, add one day to the number of days after February 28. Upcoming leap years include 2024 and 2028.

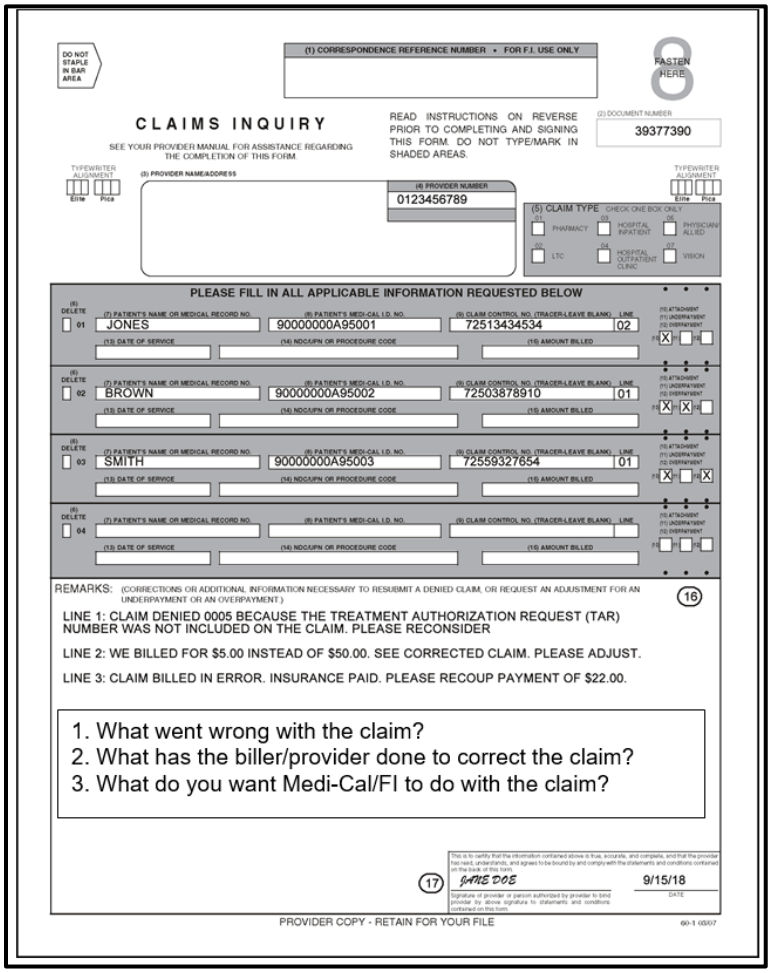
Claims Follow-Up Forms

Claims Inquiry Form (CIF)

The CIF is used to resolve claim payments or denials as identified on the RAD. There are four main reasons to submit a CIF:

- Trace a claim (does not keep claims timely).
- Request reconsideration of a denied claim.
- Adjust an underpayment or overpayment of a claim.
- Request Share of Cost (SOC) reimbursement.

Sample: Claims Inquiry Form (CIF 60-1)



DO NOT STAPLE IN BAR AREA

(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

FASTEN HERE

CLAIMS INQUIRY

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER: 39377390

TYPEWRITER ALIGNMENT Elite Pica

(3) PROVIDER NAME/ADDRESS

(4) PROVIDER NUMBER: 0123456789

(5) CLAIM TYPE CHECK ONE BOX ONLY
01 PHARMACY (2) HOSPITAL INPATIENT 06 PHYSICIAN/ ALLIED
02 LTC 04 HOSPITAL OUTPATIENT CLINIC 07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(13) DATE OF SERVICE	(14) NDC/UPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(10) ATTACHMENT (11) UNDERPAYMENT (12) OVERPAYMENT
01	JONES	90000000A95001	72513434534	02				X
02	BROWN	90000000A95002	72503878910	01				X X
03	SMITH	90000000A95003	72559327654	01				X X
04								

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.) (16)

LINE 1: CLAIM DENIED 0005 BECAUSE THE TREATMENT AUTHORIZATION REQUEST (TAR) NUMBER WAS NOT INCLUDED ON THE CLAIM. PLEASE RECONSIDER

LINE 2: WE BILLED FOR $5.00 INSTEAD OF $50.00. SEE CORRECTED CLAIM. PLEASE ADJUST.

LINE 3: CLAIM BILLED IN ERROR. INSURANCE PAID. PLEASE RECOUP PAYMENT OF $22.00.

1. What went wrong with the claim?
2. What has the biller/provider done to correct the claim?
3. What do you want Medi-Cal/FI to do with the claim?

(17) JANE DOE — 9/15/18 (DATE)

Signature of provider or person authorized by provider to bind provider to above signature to statements and conditions contained on this form.

PROVIDER COPY - RETAIN FOR YOUR FILE

60-1 05/07

Explanation of Claims Inquiry Form Items

Box #	Field Title	Description
1	Correspondence Reference Number.	For the FI use only.
2	Document Number.	The pre-imprinted number identifying the CIF.
3	Provider Name/Address	Enter the following information: Provider Name, Street Address, City, State and ZIP code.
4	Provider Number	Enter the provider number.
5	Claim Type	Enter an “X” in the box indicating the claim type. Only one box may be checked.
6	Delete	Enter an “X” to delete the entire line. When box 6 is marked “X,” the information on the line will be “ignored” while the system continues to process the other claim lines. Enter the correct billing information on another line.
7	Patient’s Name or Medical Record Number	Enter up to the first 10 letters of the patient’s last name or the first 10 characters of the patient’s Medical record number.
8	Patient’s Medi-Cal ID Number	Enter the recipient ID number that appears on the Remittance Advice Details (RAD) showing adjudication of that claim.
9	Claim Control Number	Enter the 11-digit Claim Control Number (CCN) in the Claim control No. box, and the two-digit number in the adjoining Line field for the claim line in question. These numbers are assigned by the Fiscal Intermediary (FI) and are found on the RAD. If this item is blank, the inquiry line will be considered a tracer request.
10	Attachment	Enter an “X” when attaching documentation and when resubmitting a denied claim.
11	Underpayment	Enter an “X” for an underpayment
12	Overpayment	Enter an “X” for an overpayment if all or part of the claim was denied.

Explanation of Claims Inquiry Form Items, Continued

Box #	Field Title	Description
13	Date of Service	In six-digit format (MMDDYY), enter the date the service was rendered. For block-billed claims, enter the “From” date of service.
14	NDC/UPN or Procedure Code	Providers should enter the appropriate procedure code, modifier, drug or supply code if applicable. Codes of fewer than 11 digits should be left-justified. For outpatient claims, do not enter the revenue code in this field. Long Term Care and Inpatient providers leave blank.
15	Amount Billed	Enter the amount originally billed, using the right box to represent cents.
16	Remarks	Use this area to state the reason for submitting a CIF and include the corresponding line number if listing multiple claim lines on the CIF.
17	Signature	The provider or an authorized representative must sign the CIF.

Note: All claims inquiries should have attachments except when submitting a tracer. Refer to the *CIF Submission and Timeliness Instructions* (cif sub) section of the Part 2 provider manual.

CIF Completion Tips

Note: Providers can obtain CIFs, Appeal forms and envelopes free of charge by contacting the Telephone Service Center (TSC) at 1-800-541-5555

Chart of Acceptable CIF Attachments

CIF Completion Reminders	All Inquiries	Adjustments	Crossover, Inpatient and Pharmacy Compounds	Denial	SOC	Tracer
Always enter an "X" in the box to indicate the claim type.	Yes	No	No	No	No	No
Enter no more than four claim inquiries per form. **Note:** This does not apply to crossover and inpatient claims.	Yes	No	No	No	No	No
Fill out each line completely. Do not use ditto marks (") or draw an arrow to indicate repetitive information.	Yes	No	No	No	No	No
All information must be exactly the same as that on the RAD. For example, an incorrect ID number on the RAD should be copied exactly on the CIF.	Yes	No	No	No	No	No
Only one claim line per CIF.	No	No	Yes	No	No	No
Be sure the recipient ID number and Claim Control Number on the CIF exactly match the numbers on the RAD.	Yes	No	No	No	No	No
RAD not required.	No	No	No	No	Yes	Yes

Chart of Acceptable CIF Attachments (continued)

CIF Completion Reminders	All Inquiries	Adjustments	Crossover, Inpatient and Pharmacy Compounds	Denial	SOC	Tracer
Enter the recipient's original ID (the number issued prior to being enrolled in a no-SOC program).	No	Yes	No	No	Yes	No
Do not use the *Remarks* area for additional inquiries.	Yes	No	No	No	No	No
State clearly and precisely what is being requested in the *Remarks* area.	Yes	No	No	No	No	No
Always indicate the denial or adjustment reason code in the *Remarks* area.	No	Yes	No	Yes	No	No
Secure documentation to the upper right-hand corner of the CIF.	No	Yes	Yes	Yes	Yes	No
Do not attach any documentation.	No	No	No	No	No	Yes
Only original CIFs are accepted. Photocopies will be returned.	Yes	No	No	No	No	No

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CIF Adjustments – Underpayment/Overpayment and Voids

A CIF adjustment should be used to correct both under and over payments. However, this transaction type is different than requesting a full payment recovery, which is a void.

CIF Adjustments – One-Step Process

If requesting an adjustment for an underpaid or overpaid claim, the adjustment is completed in one transaction, with the adjudication results appearing on a future RAD. The corrected CCN will appear as a credit and debit and be reflected on the same RAD.

CIFs submitted for underpayments must be received within six months from the date of the RAD. CIFs received after six months on which the underpayment was indicated are subject to an automatic denial.

CIF Voids

A CIF void can be requested to fully recover or recoup monies paid. In many instances, the provider's goal is to return funds. The CIF void process accomplishes this in one-step. However, if the provider wishes to void the original payment and submit a corrected claim, this cannot be done. The CIF void is largely an automated process and cannot perform two functions; therefore, only the void can be processed.

CIF Adjustments – Two-Step Process

Providers requiring a void and subsequent resubmission of a corrected claim, must use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RAD, the provider completes the second step by submitting an *Appeal* to request the processing of the corrected claim. If a provider submits a corrected claim before the void appears on the RAD, the claim may deny as a duplicate, since the original claim has not yet completed the void process.

Note: The *Appeal* must be filed within 90 days from the date indicated on the RAD on which the void appeared and must include a copy of the corrected claim, a copy of the RAD that indicated the payment retraction and any other supporting documentation.

Reconsideration

To request reconsideration of a denied claim line after the six-month billing limit, attach a legible copy of the corrected original claim form, a copy of the RAD dated within six months of the denial date and all pertinent documentation.

Trace

Provider has no record of payment or denial of a previously submitted claim exists on the RAD and a provider wants to trace the status of a claim. Tracers may be submitted any time. However, the CIF processing system will only find information from the past 36 months of adjudicated claims. If a tracer is being used to prove timely submission of a claim, it must be received within the same six-month billing limit for claims.

Share of Cost (SOC)

SOC reimbursement requests are considered to be a form of adjustment. *Claims Inquiry Forms* (CIFs) submitted for Share of Cost reimbursement services require unique completion instructions. All SOC inquiries on a CIF must be for SOC reimbursement only.

Where to submit CIFs

CIFs should be submitted in black and white envelopes available from the California MMIS Fiscal Intermediary to the following address:

California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

Claims Inquiry Form Attachments

The following attachments are required for CIFs as they apply to the claim, except CIFs used as tracers or CIFs requesting SOC reimbursements:

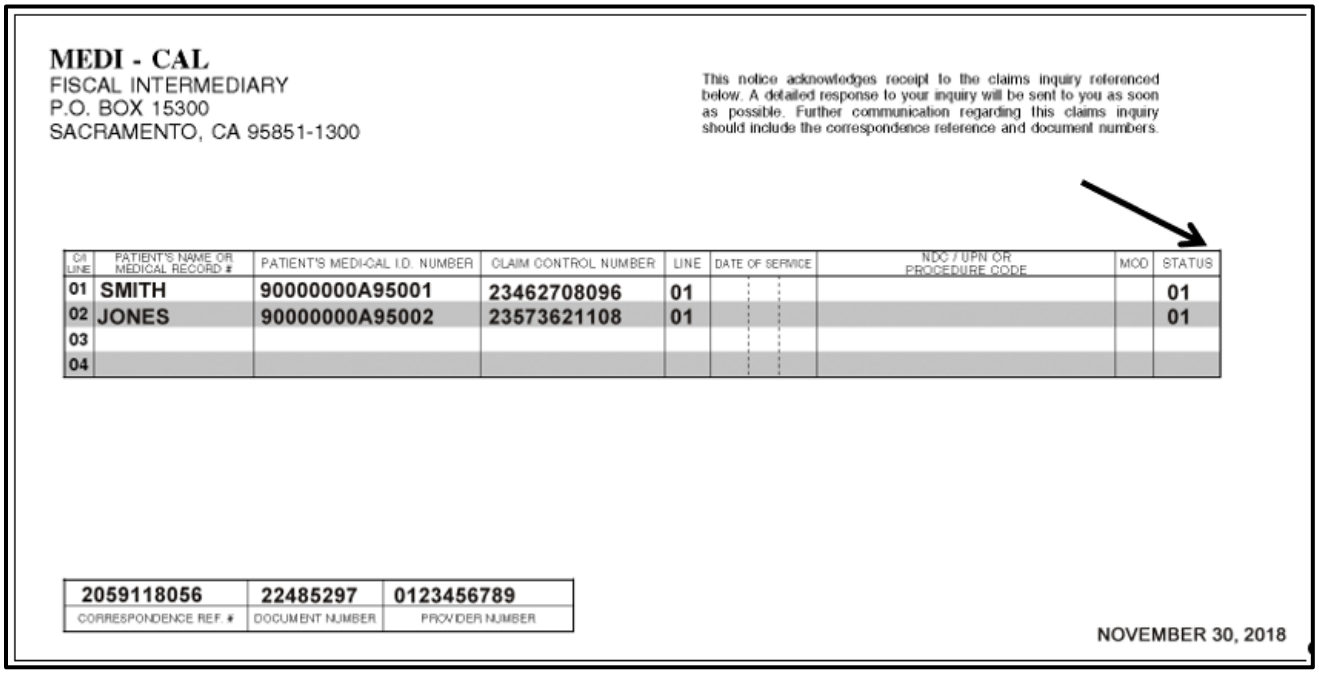
- TAR indicating authorization
- "By Report" documentation
- Completed *Sterilization Consent Form* (PM 330)
- *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)/*National Standard Intermediary Remittance Advice* (Medicare RA)
- *Explanation of Benefits* (EOB) from Other Health Coverage (OHC)
- Drugs and supplies itemization list, manufacturer's invoice or description, including the name of the medication, dosages, strength and unit price
- Supplier's invoice, indicating wholesale price and the item billed
- Manufacturer's name, catalog (model) number and manufacturer's catalog page, showing suggested retail price
- Internet eligibility response attached to the claim on an 8 ½ x 11-inch sheet of white paper

Note: All supporting documentation must be legible.

Claims Inquiry Acknowledgement

Within 15 days of receipt, the California MMIS Fiscal Intermediary acknowledges requests for adjustments and reconsideration of denied claims with a *Claims Inquiry Acknowledgement*. The claim should appear on a RAD within 45 days after the *Claims Inquiry Acknowledgement* is received. The *Claims Inquiry Acknowledgement* serves as proof of timely submission if additional claim follow-up is needed. If the California MMIS Fiscal Intermediary does not respond after the initial CIF is filed, providers should file an appeal.

Sample: *Claims Inquiry Acknowledgement*



MEDI - CAL
FISCAL INTERMEDIARY
P.O. BOX 15300
SACRAMENTO, CA 95851-1300

This notice acknowledges receipt to the claims inquiry referenced below. A detailed response to your inquiry will be sent to you as soon as possible. Further communication regarding this claims inquiry should include the correspondence reference and document numbers.

CII LINE	PATIENT'S NAME OR MEDICAL RECORD #	PATIENT'S MEDI-CAL I.D. NUMBER	CLAIM CONTROL NUMBER	LINE	DATE OF SERVICE	NDC / UPN OR PROCEDURE CODE	MOD	STATUS
01	SMITH	90000000A95001	23462708096	01				01
02	JONES	90000000A95002	23573621108	01				01
03								
04								

2059118056	22485297	0123456789
CORRESPONDENCE REF. #	DOCUMENT NUMBER	PROVIDER NUMBER

NOVEMBER 30, 2018

Table: Status Numbers and Corresponding Messages for Claims Inquiry Acknowledgement

Status Numbers	Messages
01	Accepted for resubmission of denied claim or underpayment/overpayment.
02	Accepted. Tracer status letter will be generated.
03 thru 05	Rejected. Only one CCN per crossover CIF allowed.

Claims Inquiry Response Letter

A *Claims Inquiry Response* letter indicating the status of the claim is sent to providers when the CIF/tracer is processed. The letter includes a 13-digit Correspondence Reference Number (CRN), which contains the Julian date the CIF/tracer was received and can be used to verify that the CIF/tracer was submitted within the six-month billing limit.

If the response letter states the claim cannot be located, resubmit the claim as an appeal. Enclose any necessary attachments, including a copy of the *Claims Inquiry Response* letter.

Providers may receive a *Claims Inquiry Response* letter requesting additional information. To submit a new CIF, follow the instructions in the response letter.

Exceptions to Using CIFs

- Incorrect provider number was used
- All claims denied for National Correct Coding Initiative (NCCI)
- Denied inpatient claims if claim lines must be added or deleted
- Suspended claims appearing on a current *Remittance Advice Details* (RAD) form
- RAD Code denials: 0002, 0010, 0072, 0095, 0326, 0525, 9941 and 9942 (Appeals should be submitted)

Appeal Form

The appeal process offers Medi-Cal providers who are dissatisfied with the processing of a claim, the resubmission of a claim or CIF a method for resolving their dissatisfaction.

An appeal must be submitted on an *Appeal* form (90-1). An *Appeal* form only allows a single recipient; therefore, a form must be completed for each individual.

Sample Appeal Form 90-1 Example

DO NOT STAPLE IN BAR AREA

(1) APPEAL REFERENCE NUMBER
F.I. USE ONLY

FASTEN HERE 2

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

APPEAL

(2) DOCUMENT NUMBER GXXXXXXX

TYPEWRITER ALIGNMENT ELITE PICA

TYPEWRITER ALIGNMENT ELITE PICA

(3) PROVIDER NAME/ADDRESS

ABC PROVIDER
1234 MAIN STREET
ANYTOWN CA 958235555

(4) PROVIDER NO. 0123456789

(5) CLAIM TYPE
CHECK ONE BOX ONLY

- 01 [ ] PHARMACY
- 02 [ ] LTC
- 03 [ ] HOSPITAL INPATIENT
- 04 [ ] HOSPITAL OUTPATIENT/ CLINIC
- 05 [X] PHYSICIAN/ ALLIED
- 07 [ ] VISION

(6) AS PROVIDED BY THE CALIFORNIA ADMINISTRATIVE CODE. TITLE 22, SECTION 51015 (b-d). I AM SUBMITTING AN APPEAL OF MY CLAIM AS DEFINED BELOW. ENCLOSED ARE ALL THE PERTINENT DOCUMENTS CORRESPONDING TO THIS APPEAL, INCLUDING COPIES OF THE CLAIM. EOB/RA, CIF's, MEDICARE EOMB/RA AND ANY PREVIOUS CORRESPONDENCE WITH THE MEDI-CAL FISCAL INTERMEDIARY.

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(7) PATIENT'S NAME OR MEDICAL RECORD NO.: SMITH

(8) PATIENT'S MEDI-CAL I.D. NO./SSN: 90000000A95001

(13) **REASON FOR APPEAL:** (ENCLOSED ALL SUPPORTING DOCUMENTS, INCLUDING CLAIM COPY)

1. PLEASE SEE ATTACHED REPORT. WE SUBMITTED A CIF BUT THE CLAIM WAS DENIED AGAIN FOR DOCUMENTATION. PLEASE RECONSIDER.
2. QUANTITY BILLED WAS 2, ONLY PAID 1. PLEASE ADJUST THIS UNDERPAYMENT.
3. BILLED IN ERROR. PLEASE RETRACT PAYMENT.

(9) DELETE		(10) CLAIM CONTROL NO.	(11) DATE OF SERVICE	(12) EOB/RA CODE
[ ]	01	1234567890123		
[ ]	02	1234567890124		
[ ]	03	1234567890125		
[ ]	04			
[ ]	05			
[ ]	06			
[ ]	07			
[ ]	08			
[ ]	09			
[ ]	10			
[ ]	11			
[ ]	12			
[ ]	13			
[ ]	14			

(14) COMMON APPEAL REASON
CHECK ONLY ONE (IF APPLICABLE)

- [ ] ELIGIBILITY (POE ATTACHED)
- [ ] TAR DENIAL (TAR ATTACHED)
- [ ] CROSSOVER (EOMB ATTACHED)
- [ ] ADJUSTMENT REQUEST (PAID WARRANT ATTACHED)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

(15) *Jane Smith*
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

030118
DATE

FORM# 90-1 (3/07)

Explanation of Appeal Form Items

Box #	Field Title	Description
1	Appeal Reference Number	For FI use only.
2	Document Number	The pre-imprinted number identifying the *Appeal Form*. This number can be used when requesting information about the status of an appeal.
3	Provider Name/Address	Enter the following information: Provider Name, Street Address, City, State, and ZIP code.
4	Provider Number *(required field)*	Enter the provider number. Without the correct provider number, appeal acknowledgement may be delayed.
5	Claim Type (*required field*)	Enter an “X” in the box indicating the claim type. Only one box may be checked.
6	Statement of Appeal	For information purposes only.
7	Patient’s Name or Medical Record Number	Enter up to the first 10 letters of the patient’s last name or the first 10 characters of the patient’s medical record number.
8	Patient’s Medi-Cal ID Number/SSN *(required field)*	Enter the recipient ID number that appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.
9	Delete	If an error is made, enter an “X” in this box to delete If an error is made, enter an “X” in this box to delete information on the line will be “ignored” by the system and will information on the line will be “ignored” by the system and will not be processed as an appeal line. Enter the correct billing information on another line.
10	Claim Control Number *(required field if appealing a previously adjudicated claim).*	Enter the 13-digit number assigned by the FI to the claim line in question. (This number is found on the *Remittance Advice Details* [RAD]). This field is not required when appealing a non-adjudicated claim (for example, a “traced” claim that could not be located).

Explanation of Appeal Form Items, Continued

Box #	Field Title	Description
11	Date of Service	In six-digit format (MMDDYY) enter the date the service was rendered. For claims billed in a “from- through” format, you must enter the “from” date of service.
12	RAD Code or EOB/RA Code	When appealing, enter the RAD code being appealed, (for example, 010, 072, 401).
13	Reason for Appeal	Indicate the reason for filing an appeal. Be as specific as possible. Include all supporting documentation to help examiners properly research the complaint.
14	Common Appeal Reason	Check one of these boxes if applicable. Include a copy of the claim and supporting documentation (for example, TAR, EOMB). This box is for convenience only. Leave Box 13 blank if this box is used.
15	Signature	The provider or an authorized representative must sign the *Appeal Form.*

Appeals should be mailed in the purple and white envelopes available from the California MMIS Fiscal Intermediary. Providers should send appeals to the California MMIS Fiscal Intermediary at the following address:

Attn: Appeals Unit
California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

All supporting documentation must be legible. The following attachments as they apply to the claim are acceptable:

- Corrected claim, if necessary
- RADs pertaining to the claim history
- *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)
- Other Health Coverage (OHC) payments or denials
- All CIFs, Claims Inquiry Acknowledgements, *Claims Inquiry Response* letters or other dated correspondence to and from the California MMIS Fiscal Intermediary documenting timely follow-up
- Reports for "By Report" procedures
- Manufacturer's invoice or catalog page
- Completed *Sterilization Consent Form* (PM 330)
- *Treatment Authorization Request* (TAR) or Service Authorization Request (SAR)

The California MMIS Fiscal Intermediary will acknowledge appeals within 15 days of receipt and make a decision within 45 days of receipt. If a decision is not made within 45 days, the appeal is referred to the Professional Review Unit for an additional 30 days.

Appeal Form Completion Process

Complete the fields on the *Appeal* form according to the type of inquiry. Resubmission, underpayment and overpayment requests for the same recipient may be combined on one form.

Table of Appeal Form 90-1 Fields and Instructions

Field Numbers	Completion Instructions
3, 4, 5, 7, 8, 10, 11 and 12	These fields are required for all appeal types.
4, 5, 8 and 10	*Provider Number, Claim Type, Patient's Medi-Cal ID Number* and *Claim Control Number* are completed to process an appeal. If these fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected *Appeal* form and all supporting documentation, proof of timely follow-up and submission.

Note: The correct recipient ID number must be entered in Box 8 (*Patient's Medi-Cal ID No.*) even if the RAD reflects an incorrect recipient ID number.

Appeal Form Completion Tips

Appealing a Denial

If appealing a denial, enter the denial code from the RAD in Box 12.

Underpayment and Overpayment

If requesting reconsideration of an underpayment or overpayment, enter the payment code from the RAD in Box 12.

Adjustments

If requesting an adjustment, attach a legible copy of the original claim form, corrected if necessary, and a copy of the corresponding paid RAD. If requesting an overpayment adjustment because the patient named is not a provider's patient, attach only a copy of the paid RAD.

Signatures

Sign and date the bottom of the form. All appeals must be signed by the provider or an authorized representative. Appeals submitted without a signature will be returned to the provider.

Electronic Claim Resubmission to avoid Paper CIFs/Appeals

Providers can electronically resolve a claim denial or incorrect payment for 837I (Institutional) and 837P (Professional) electronic claims.

By submitting the claim with either frequency type code “7” (replacement of prior claim) or “8” (void/cancel of prior claim), there is no longer a need to adjust the claim using a paper *Claims Inquiry Form* (CIF) or *Appeal* forms with accompanying *Remittance Advice Details* (RADs) to show proof of previous claim payment or denial. Electronic claim resubmission is not available for pharmacy claims.

The ANSI X12 v.5010 837 electronic transactions claim format allows a provider to initiate changes to already-adjudicated claims. The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.”

Replacement and void claims can be sent in the same batch as new claims. Electronic replacement claims must be submitted within six months of the previous claim payment or denial. Providers may submit an electronic follow-up claim even if the original was a paper claim. Claims for which a CIF or appeal are already in progress must not be electronically resubmitted. Claims for which a CIF or appeal is in progress will be denied.

The following chart outlines the use of codes “7” and “8”.

Table of Frequency Type Codes 7 and 8

Claim Frequency Code/Definition	Use	Filing Guidelines	Result
7 Replacement of Prior Claim	Use to replace a claim line or entire claim in an already adjudicated paid or denied claim (see following instructions per claim type)	File the claim line or entire electronic claim including all services for which reconsideration is requested	Medi-Cal will adjust the original claim. The corrections submitted will be reflected on the 835 Transaction and/or paper *Remittance Advice Details* (RAD) and other standard claim responses
8 Void/Cancel of Prior Claim	Use to eliminate an already adjudicated claim for a specific provider, recipient and date of service (see following instructions per claim type)	File the claim electronically and include all claims data and charges that were on the original claim	Medi-Cal will void the original claim from history based on request, which will be reflected on the 835 Transaction and/or paper RAD and other standard claim responses

Frequency Type Code ‘7’

Electronic **allied health, long term care, medical services, obstetric, outpatient and vision care** claims resubmitted with Frequency Type code “7” (replacement claim):

- Are used to modify only one claim line. They cannot be used to replace multiple original claim lines.
- Must include a separate replacement claim transaction for each claim line being replaced. For example, to replace all five lines of an outpatient claim, the submitter must submit five separate transactions.
- Must contain corrected information for the original claim.
- Must include the 13-digit Claim Control Number (CCN) from the original paid claim. For the claim to be considered for full reimbursement, the RAD date for the previous claim payment or denial must be within six months of the date the replacement claim was submitted.

Electronic **inpatient** claims resubmitted with Frequency Type code “7” (replacement claim):

- Replace the entire inpatient care claim.

Frequency Type Code ‘8’

Electronic **long-term care, medical services, outpatient and vision care** claims resubmitted with Frequency Type code “8” (void/cancel claim):

- Must include the 13-digit CCN from the original paid claim.
- Serve as a full void for one claim line only. Multiple original claim lines cannot be voided with one void claim transaction.
- Must include a separate void claim transaction for each claim line being voided. For example, to void all five lines of an outpatient claim, the submitter must submit five separate transactions.

Electronic **inpatient** claims resubmitted with Frequency Type code “8” (void/cancel claim):

- Void the entire inpatient care claim.

Errors to Avoid

Providers should pay attention to the instructions above that certain claim types can replace or void one claim line only. Additionally, the CCN of the original claim is the proper information to insert in the REF segment.

Correct CCN for Crossover Claims

Providers resubmitting a Medicare to Medi-Cal crossover claim should take care to enter the CCN from the Medi-Cal claim they are resubmitting and not the CCN from the Medicare claim.

Claim Attachments

Attachments required with the initial claim submission are required for replacement claim submissions. Copies of claims initially submitted on paper are not needed. Information from the paper claim will already have been keyed into the claims processing system.

No attachments are required when voiding a claim.

Information about submitting attachments for electronic claims is available in the *Billing Instructions: Acceptable Claims, Attachments and ASC X12N 835 v.5010 Transactions* section of the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*, specifically under the following headings:

- “Supporting Documentation – Attachments”
- “Attachment Control Form: Required and Optional Fields”
- “Attachment Control Form (ACF) Guidelines”

Associated RAD Code and Correlation Table Update

The following Remittance Advice Details (RAD) message has been added in the *RAD Repository* to help providers reconcile claims submitted using claim frequency code “7” (The claim frequency code is the third digit of the “Type of Bill” Code.)

9174 RAD Code Table

Code	Message
9174	Computer Media Claims (CMC) replacement submitted after six months of referred claim *Remittance Advice Details* (RAD) is not payable

Reimbursement

If the initial adjudicated claim was subject to a reimbursement reduction due to late claim submission, then reimbursement for the resubmitted claim also will be reduced.

Correspondence Specialist Unit (CSU)

The Correspondence Specialist Unit (CSU) resolves complex billing issues. TSC agents may refer you to the CSU for inquiries that require additional research.

Providers may write directly to CSU for clarification about recurring billing issues that have not been resolved through either the *Claims Inquiry Form* (CIF) or Appeal process and have resulted in claim denials. Correspondence Specialists respond to providers in writing to clarify billing procedures.

When writing to CSU for assistance, providers should enclose up to three examples of Claim Control Numbers (CCNs) to help establish the history in order to resolve the billing issues. Include as much of the following documentation as possible with the letter of inquiry:

- Legible with claim form.
- Proof of eligibility.
- Necessary documentation, operative report, invoice, etc.
- Copies of Remittance Advice Details (RAD).
- Copies of all CIF acknowledgements, response letters.
- Copies of all Appeal acknowledgements, response letters.
- Copies of all dates correspondence from the previous/current California MMIS Fiscal Intermediary.

A lack of necessary records may delay research.

Letters to CSU should be addressed to the California MMIS Fiscal Intermediary in a plain white envelope as follows:

Attn: Correspondence Specialist Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

New Provider Financial Data Request Form

Providers are now able to utilize the Provider Financial Data Request Form (4520), when requesting financial data from the Financial Cash Control Unit (FCCU). Using this form will enable Providers to save time determining what is needed for questions regarding missing warrants, copies of RADs, accounts receivable transactions and copies of 1099's.

Providers reaching out to the FCCU for assistance with any of these services must complete the Provider Financial Data Request Form. Please note that each form may only contain a single request and must be filled out in its entirety including provider number, reason for request and signature to avoid delays due to missing information.

Mail the completed form to the following address:

California MMIS Fiscal Intermediary
Attn: Financial Cash Control Unit
P.O. Box 13029
Sacramento, CA 95813-4029

Medi-Cal Provider Appeals Packet Checklist

Instructions: Before mailing an appeal to Medi-Cal please review this checklist and make sure you have all pertinent documents. **Simply mark an ☒ next to all that apply.**

- ☐ I have reviewed the *Appeal Form Completion* section in the Part 2 manual for *Appeal* form (90-1) completion instructions
- ☐ Medi-Cal *Appeal* form (90-1) complete
- ☐ If appeal is for a claim that may be an underpayment or overpayment, then enter payment code found on the RAD in Box 12
- ☐ If appeal is for claim denial then enter the denial code from the RAD in Box 12 on Form (90-1)
- ☐ For an overpayment adjustment because the patient named is not the provider's patient, then attach only a copy of the paid RAD to *Appeal* form (90-1)
- ☐ Copy of original claim
- ☐ *Remittance Advice Details*
- ☐ *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)
- ☐ *Treatment Authorization Request* (TAR) or Service Authorization Request (SAR)
- ☐ Health coverage payments or denials
- ☐ *Claims Inquiry Form*
- ☐ Claims Inquiry Acknowledgements
- ☐ *Claims Inquiry Response* letters
- ☐ All dated correspondence sent to Medi-Cal
- ☐ All dated correspondence received from Medi-Cal documenting timely follow-up *(must be on California MMIS Fiscal Intermediary letterhead)*
- ☐ Reports for “By Report” procedures
- ☐ Manufacturer’s invoice or catalog page
- ☐ Lab reports showing different times or sites for multiple procedures
- ☐ If appeal is for a claim that bills for twins, ensure each twin (Twin A or Twin B) is correctly indicated on the claim in the *Patient’s Name* field (Box 2)
- ☐ Attach proof of recipient eligibility if date of service (DOS) is over 15 months or last denial was for eligibility
- ☐ Completed *Sterilization Consent Form* (PM 330)
- ☐ I have signed and dated the bottom of *Appeal* form (90-1) *(All appeals must be signed by the provider or an authorized representative for the provider. Appeals submitted without a signature will be returned to the provider)*

Resource Information

References

The following reference materials provide Medi-Cal claim information.

Provider Manual References

Part 1

Claim Submission and Timeliness Overview (claim sub)
Remittance Advice Details (RAD) and Financial Summary; Click link: Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations

Part 2

Appeal Form Completion (appeal form)
CIF Completion (cif co)
CIF Submission and Timeliness Instructions (cif sub)
CMS-1500 Completion (cms comp)
CMS-1500 Submission and Timeliness (cms sub)
UB-04 Completion: Outpatient Services (ub comp ob)
UB-04 Submission and Timeliness (ub sub)

Resource Tools

Medi-Cal Providers website

Telephone Service Center (TSC):

1-800-541-5555

Provider Field Representatives:

Call the TSC and ask for a Provider Field Representative to visit your office.