CBHS100
MENTAL HEALTH SERVICES (MHS) and DRUG AND ALCOHOL SERVICES (DAS) PROVIDER DATA FORM

The purpose of this Provider Data Form (CBHS100) is to facilitate and track the set up of a new Mental Health (MHS) or Drug and Alcohol Services (DAS) provider [1] and to update provider setup information.

This form is not intended for use in setting up or implementing individual Fee for Service Practitioner Providers who are managed by the Provider Systems Office (PSO.)

- CBHS Program Managers must contact Behavioral Health Billing Information Systems (BHBIS) prior to initiating a new provider number request to the state to ensure a provider number is not already available for use in the Billing application system.
- CBHS Program Managers must contact DPH Fiscal Cost Reporting Unit (554-2524) for new Legal Entity (LE[2]) and Provider numbers for Mental Health (MH) only programs. To change or to add Mode/SFC to an existing MH Program, contact DPH Fiscal Cost Reporting Unit.
- Programs who provide only Drug and Alcohol (DA) services, the CBHS Program Manager is responsible to obtain new Provider numbers.
- Programs who provide both MH and DA services, CBHS Program Managers contact the DPH Fiscal Unit.
- Contact **HOTLINE** for assistance in updating existing provider information.

Instructions for NEW Provider Set-up

The CBHS Program Managers are responsible for completing and distributing this form as follows:

1. Initiate the contract process.
2. For MHS programs attach to the CBHS100 form a copy of the CRDC as developed through the contract process. **For Substance Abuse programs, attach a copy of the Contract Budget Summary.**
3. Obtain Fire Clearance for the proposed address.
4. For Short Doyle Medi-Cal Providers, initiate the Medi-Cal certification process. Contact CBHS Performance & Compliance Unit, Provider Relations – Provider Certifications Office.
5. If the Provider is MediCare certified or if certification is required, contact Provider Certifications Office.
6. Complete the information in Part I, and Part II (MHS) or III (Drug and Alcohol Services), include any Provider/ RU attributes that may affect billing.
7. Determine the name for the new Reporting Unit using the following criteria:
   - Name cannot exceed 38 characters
   - Names may not be duplicated
   - Contact the BHBIS Business Analyst for an RU[3] number
8. Obtain signatures on Part IV and distribute the form as indicated in the Distribution list (last page).
9. The BHBIS Business Analyst will notify the concerned parties when the setup is complete in InSyst

Instructions for CHANGES in Provider Data

The purpose of the change in Provider Data process is to facilitate and track changes to add, close, or change information for Providers. CBHS Program Managers are responsible for filling out a CBHS100 form and retaining a copy of the form. Follow the instructions below and send copies to the distribution list.

1. **To Close an RU:** Attach a copy of the original CBHS100 form Part I and Part II (MHS) or Part III (DAS) page for each mode of service to be closed. Write "CLOSE RU" at the top of the page with the effective closing date. Contact CBHS Business Analyst if you do not have an original CBHS100.
2. **To Add, Delete, Change Procedure Codes:** Attach Part II (MHS) or Part III (DAS) with notes indicating what services are to be added or changed and attach the CRDC sheet (MHS).
3. **To Change Populations Served or Payor Sources:** Attach Part II (MHS) or Part III (DAS) with notes indicating changes
4. **To Change Legal Entity (LE) or Address Information:** If a program is changing to a different LE, you must get a new Provider Number and complete a CBHS100 as a new provider (for MHS).
5. **To Change Address Information:** For Medi-Cal programs, a re-certification is required when the provider site address changes. Attach Part I with notes indicating all changes needed.
6. **To Change RU Name:** Complete Part I and check the appropriate MHS or DAS box.
7. **To Change Head of Service (Clinical, Medical Director), Program Director or Legal Entity Director**: Complete Part I and check the appropriate MHS or DAS box. **Note:** Part IV Signature page is required *for all changes.*

******SUBMIT ONLY THE PAGES YOU FILLED OUT.*****

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[1] A provider is defined as the directing Organizational Healthcare entity. State assigns a 4-digit number for each single address site.
[2] LE is the corporate entity with fiduciary responsibility for a program. LE has a 5-character number assigned by the State.
[3] Reporting Unit is defined as a Healthcare delivery entity, having a 5- or 6-character Reporting Unit (RU) number assigned by the BHBIS unit, based on the 4-digit provider number and a 1 or 2 digit qualifying suffix. Reporting Units must be set up at the time the Provider is established. Generally, a separate RU number is required for each mode of service planned.

RU# _____

Part I: New Program and Provider Information

Check the box that applies

This provider is ☐ MHS Provider ☐ DAS Provider ☐ Civil service ☐ Contract ☐ Private Hospital/Facility

Do not use this form for Private Provider Network (PPN) individual practitioner providers. Contact CBHS Provider Relations Office, (415) 255-3723 for PPN Providers.

Program /RU Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Fax: _____ TT/TDD: _____

Program Director Name: _____ Phone: _____

Contact Person (if different) _____ Phone: _____ E-Mail: _____

Data Entry Person 1: _____ Phone: _____ ☐ Current BIS User ☐ New User

Data Entry Person 2: _____ Phone: _____ ☐ Current BIS User ☐ New User

Medi-Cal Director Name: _____ Phone: _____ E-Mail _____

CBHS Program Manager: _____ Phone: _____

Language Capacity

At this address services are available in English and the following additional languages:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

National Provider Identifier #: Parent /Umbrella Org. _____ **Facility:** _____

Taxonomy Codes (if applicable): _____ **Medicare PTAN (for MHS only):** _____

Legal Entity number (MHS ONLY): _____ **Legal Entity Name (MHS Only):** _____

Start Date for Reporting Unit (RU): _____
(The date the Provider is scheduled to open its doors or the effective date for the new RU)

DRUG AND ALCOHOL SYSTEM ONLY

Umbrella Organization Name: _____

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ TT/TDD: _____

Exe. Director Name: _____ Phone: _____

RU# _____

Part II-Mental Health Services: 24-Hour Services (Mode 5)

(If Mode 45, 55 and/or 60 will be provided in addition to Mode 5, complete Part II for each mode separately.)

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Number of Beds: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____
(RU is Closing)

Define services (using Service Function Codes [SFC]) to be provided by the Program/RU

Special Instructions: Attach a copy of the CRDC and complete information below from the CRDC.
Be sure all Service Function Codes (SFCs) assigned to the RU are included in the final contract.

Place a check mark (√) to indicate services apply to this RU.

YES	SFC Range	Description	YES	SFC Range	Description (Non-Medical Billable)
	10-18	Hospital Inpatient		30-34	SNF Intensive
	19	Hospital IP Administrative Day		35	IMD-no patch
	20-29	Psychiatric Health Facility		36-39	IMD with patch
	40-49	Adult Crisis Residential		60-64	Residential Other
	65-79	Adult Residential		80-84	Semi-Supervised Living
				85-89	Independent Living
				90-94	MH Rehab Center

RU Target Population		Payor Sources
☐ ADULT ☐ GERIATRICS (Age 60+) ☐ HIV+ ☐ MENTALLY ILL/SUBSTANCE ABUSERS ☐ MINORITY ☐ DEVELOPMENTALLY DISABLED ☐ CHILDREN (Age 0-17) ☐ AB3632		☐ SF County ☐ Medi-Cal (requires cert) ☐ Medicare ☐ Insurance ☐ Client ☐ Other: _____ ☐ Not for billing, for tracking only **Grant Funded** (Name & Time Period) (from _____ to _____) ☐ Federal: _____ ☐ State: _____ ☐ Other: _____ **Work Order** _____

RU#_____

Part II--Mental Health Services: Day Treatment Services (Mode 10)

(If Mode 45, 55 and/or 60 will be provided in addition to Mode 10, complete Part II for each mode separately.)

RU Name:_____

Circle Days of Operation: S M T W TH F S

Hours of Operation:_____

Effective Billing Start Date:_____ **Effective Billing Stop Date:**_____ (if closing)

Define services to be provided by the Program/RU

Special Instructions: Attach a copy of the CRDC and complete information below from the CRDC.
Be sure all Service Function Codes (SFCs) assigned to the RU are included in the final contract.

Place a check mark (√) to indicate services apply to this RU.

YES	SFC Range	Description
	20-24	Crisis Stabilization-Emergency Room. (Must have Staff Physician).
	25-29	Crisis Stabilization-Urgent Care. (Must have Staff Physician).
	81-84	Day TX Intensive-Half Day (Up to 4 hours)
	85-89	Day TX Intensive-Full Day (More than 4 hours)
	91-94	Day TX Rehabilitative-Half Day (Up to 4 hours)
	95-99	Day TX Rehabilitative-Full Day (More than 4 hours)
		Non Medi-Cal Billable
	30-39	Vocational Services
	40-49	Socialization
	60-69	SNF Augmentation

RU Target Population		Payor Sources
☐ ADULT ☐ GERIATRICS (Age 60+) ☐ HIV+ ☐ MENTALLY ILL/SUBSTANCE ABUSERS ☐ MINORITY ☐ DEVELOPMENTALLY DISABLED ☐ CHILDREN (Age 0-17) ☐ AB3632		☐ SF County **Grant Funded** (Time Period & Name) ☐ Medi-Cal (requires cert) (from_____to_____) ☐ Medicare ☐ Federal: _____ ☐ Insurance ☐ State: _____ ☐ Client ☐ Other: _____ ☐ Other:_____ **Work Order** ☐ Not for billing, for tracking only _____

RU# _____

Part II--Mental Health Services: Outpatient Services (Mode 15)

(If Mode 45, 55 and/or 60 will be provided in addition to Mode 15, complete Part II for each mode separately.)

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____
(RU is Closing)

Define services to be provided by the Program/RU

Special Instructions: Attach a copy of the CRDC and complete information below from the CRDC.
Be sure all Service Function Codes (SFCs) assigned to the RU are included in the final contract.

Place a check mark (√) to indicate services apply to this RU.

YES	SFC Range	Description
	01-09	Case Management Brokerage
		Mental Health Services
	10-19	Collateral
	30-38	Assessment
	40-48	Individual
	50-57	Group
	58	TBS
	60-69	Medication Support
	70-79	Crisis Intervention

Other Service Codes Added:

		CPT Codes
		Non Medi-Cal Codes
		Other Codes (Please list)

RU Target Population		Payor Sources
☐ ADULT		☐ SF County **Grant Funded** (Name & Time Period)
☐ GERIATRICS (Age 60+)		☐ Medi-Cal (requires cert) (from _____ to _____)
☐ HIV+		☐ Medicare ☐ Federal: _____
☐ MENTALLY ILL/SUBSTANCE ABUSERS (Dually Diagnosed)		☐ Insurance ☐ State: _____
☐ MINORITY		☐ Client ☐ Other: _____
☐ DEVELOPMENTALLY DISABLED		☐ Other: _____ **Work Order**
☐ CHILDREN (Age 0-17)		☐ Not for billing, for tracking only _____
☐ AB3632		

RU# _____

Part II--Mental Health Services: Indirect Services –Outreach (Mode 45) & MAA Services (Mode 55)

(If Mode 60 will be provided in addition to Mode 45 or 55, complete separate Part II for Mode 60.)

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____ (if closing)

Place a check mark (√) to indicate services apply to this RU.

Indirect Services (Mode 45)

YES	SFC Range	Description
		Indirect Services
	11	Mental Health Promotion
	21	Community Client Contact
	28	Staff Training Given
	29	Clinical Staff Development

MAA Services (Mode 55)

YES	SFC Range	Description
	01-03	Medi-Cal Outreach
	04-06	Medi-Cal Eligibility Intake
	07-09	Medi-Cal Contract Administration
	11-13	Crisis Referral
	14-16	MHS Contract Administration
	17-19	Discounted MH Outreach
	21-23	SPMP Case Management
	24-26	SPMP Program Planning
	27-29	SPMP MAA Training
	31-34	Non-SPMP Case Management
	35-39	Non-SPMP Program Planning

RU Target Population	Payor Sources
☐ ADULT ☐ GERIATRICS (Age 60+) ☐ HIV+ ☐ MENTALLY ILL/SUBSTANCE ABUSERS (Dually Diagnosed) ☐ MINORITY ☐ DEVELOPMENTALLY DISABLED ☐ CHILDREN (Age 0-17) ☐ AB3632	☐ SF County ☐ Medi-Cal (not billed on SDMC claims) ☐ MHSA ☐ Other : _____ **Grant Funded** (Name & Time Period) (from _____ to _____) ☐ Federal: _____ ☐ State: _____ ☐ Other : _____ **Work Order** _____

RU# _____

Part II--Mental Health Services: Support Services (Mode 60)

(If Mode 5, 10, 15, 45, 55 will be provided in addition to Mode 60, complete Part II for each mode separately.)

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____ (if closing)

Define services to be provided by the Program/RU

Special Instructions: Attach a copy of the CRDC and complete information below from the CRDC.
Be sure all Service Function Codes (SFCs) assigned to the RU are included in the final contract.

Place a check mark (√) to indicate services apply to this RU.

YES	SFC Range	Description
	20-29	Conservatorship Investigation
	30-39	Conservatorship Administration
	40-49	Life Support/Board & Care
	60-69	Case Management Support
	70	Client Housing Support Expenditures
	71	Client Housing Operation Expenditures
	72	Client Flexible Support Expenditures
	75	Non-Medi-Cal Capital Assets
	78	Other Non Medi-Cal Client Support Expenditures

RU Target Population		Payor Sources
☐ ADULT ☐ GERIATRICS (Age 60+) ☐ HIV+ ☐ MENTALLY ILL/SUBSTANCE ABUSERS (Dually Diagnosed) ☐ MINORITY ☐ DEVELOPMENTALLY DISABLED ☐ CHILDREN (Age 0-17) ☐ AB3632		☐ SF County ☐ Medi-Cal (not billed on SDMC claims) ☐ MHSA ☐ Other :_____ **Grant Funded** (Name & Time Period) (from _____to_____) ☐ Federal: _____ ☐ State: _____ ☐ Other :_____ **Work Order** _____

RU# _____

Part III--Drug and Alcohol Services: Outpatient Services

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____

Place a check mark (√) to indicate services apply to this RU. (If RU is closing)

	Description of Service	Procedure Code(s)	Location (Circle applicable)	Max. Minutes	Max. Minutes	SFC	Contract Rate
	Group Counseling (Non Medi-Cal)	102	Office Field Phone				
	Court Appearance for client	142	Field				
	Individual Counseling	151	Office Field Phone				
	Group Counseling (Medi-Cal)	152	Office Field Phone				
	Assessment (Medi-Cal)	154	Office Field Phone				
	Collateral (Medi-Cal)	156	Office Field Phone				
	Acupuncture	163	Office				
	Crisis Intervention (Medi-Cal)	164	Office Field Phone				
	Treatment Planning (Medi-Cal)	167	Office Field Phone				
	Case Management	168	Office				
	Relapse Prevention	169	Office				
	Urinalysis	170	Office				
	DBT OP Individual Counseling	171	Office Field Phone				
	DBT OP Group Counseling	172	Office Field Phone				
	DBT OP Assessment & TRT Planning	173	Office				
	DBT OP Collateral	174	Office Field Phone				
	DBT OP Crisis Intervention	175	Office Field Phone				
	DBT Op Case Management	176	Office				
	TB Services	190	Ofiice				
	HIV services	191	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number: _____ Cert Date: _____
☐ Perinatal Medi-Cal Number: _____ Cert Date: _____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From: _____ To: _____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence
(Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

RU# _____

Part III--Drug and Alcohol Services: Residential/ Residential Detoxification Services

RU Name:_____

Circle Days of Operation: S M T W TH F S

Hours of Operation:_____

Effective Billing Start Date:_____ **Effective Billing Stop Date:**_____
(RU is Closing)

Place a check mark (√) to indicate services apply to this RU.

Residential

Modality /Description of Service	Procedure Code(s)	Location	Max. Minutes	Max. Minutes	SFC	Contract Rate
Residential Day (Non Medi-Cal)	288	Office				
Residential Day (Perinatal Medi-Cal)	244	Office				

Residential Detoxification

Modality /Description of Service	Procedure Code(s)	Location	Max. Minutes	Max. Minutes	SFC	Contract Rate
Resid. Detox (Social Model)	241	Office				
Resid. Detox (Medically Managed)	254	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number:_____ Cert Date:_____
☐ Perinatal Medi-Cal Number:_____ Cert Date:_____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From:_____ To:_____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence (Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

RU#_____

Part III--Drug and Alcohol Services: Methadone Detoxification Services

RU Name:_____

Circle Days of Operation: S M T W TH F S

Hours of Operation:_____

Effective Billing Start Date:_____ **Effective Billing Stop Date:**_____

Place a check mark (√) to indicate services apply to this RU.

	Methadone Detoxification						
(√)	**Description of Service**	**Procedure Code(s)**	Location (Circle applicable)	Max. Minutes	Max. Minutes	SFC	Contract Rate
	M Detox Indiv. Couns: Office/ Hosp	301/ 311	Office Field Phone				
	Acupuncture	302	Office Field Phone				
	M Detox Group Couns: Office/ Hosp	312/ 332	Office Field Phone				
	M Detox dosing	321	Office				
	Urinalysis	330	Office				
	TB Services	390	Office				
	HIV services	391	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number:_____ Cert Date:_____
☐ Perinatal Medi-Cal Number:_____ Cert Date:_____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From:_____ To:_____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence (Enter 1, 2, 3 in the corresponding line below.)

___ Medi-Cal ___ General Fund ___ Grant

3. Grant applied to a _____ target population.

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

RU# _____

Part III--Drug and Alcohol Services: Methadone Maintenance Services

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____

Place a check mark (√) to indicate services apply to this RU.

Methadone Maintenance

Modality /Description of Service	Procedure Code(s)	Location (Circle applicable)	Min. Minutes	Max. Minutes	SFC	Contract Rate
MM Individual Couns: Office/ Hosp.	401/ 411	Office Field Phone				
MM Group Couns: Office/ Hosp. (Non Medi-cal)	402/ 432	Office Field Phone				
DBT MM Individual Counseling	403	Office				
DBT MM Group Counseling	404	Office				
MM Group Couns: Office/ Hosp.(Medi-cal)	452/ 472	Office Field Phone				
MM Dosing: Office/ Hosp.	420/ 421	Office Field Phone				
Urinalysis	430	Office				
Acupuncture	414	Office				
TB Services	490	Office				
HIV Services	491	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number: _____ Cert Date: _____
☐ Perinatal Medi-Cal Number: _____ Cert Date: _____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From: _____ To: _____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence
(Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

RU# _____

Part III--Drug and Alcohol Services: Prevention Services

RU Name:_____

Circle Days of Operation: S M T W TH F S

Hours of Operation:_____

Effective Billing Start Date:_____ **Effective Billing Stop Date:**_____

Place a check mark (√) to indicate services apply to this RU.

Prevention

Modality /Description of Service	Procedure Code(s)	Location (Circle applicable)	Min. Minutes	Max. Minutes	SFC	Contract Rate
Childcare	507	Office				
Child Early Intervention OP	578	Office Field Phone				
Child Early Intervention Resid.	579	Office Field Phone				
Prevention Education	576	Office Field Phone				
Alternative Services	574	Office Field Phone				
Early Intervention	571	Office Field Phone				
Referral, Screening, Intake	572	Office Field Phone				
Outreach and Intervention	573	Office Field Phone				
IVDU Services	575	Office Field Phone				
Group Intervention	583	Office Field Phone				

FUNDING SOURCE

☐ DRUG Medi-Cal Number:_____ Cert Date:_____
☐ Perinatal Medi-Cal Number:_____ Cert Date:_____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From:_____ To:_____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence (Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___General Fund ___Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

RU# _____

Part III--Drug and Alcohol Services: Clean and Sober Living

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____

Place a check mark (√) to indicate services apply to this RU.

Clean and Sober Living

(√)	Modality /Description of Service	Procedure Code(s)	Location	Min. Minutes	Max. Minutes	SFC	Contract Rate
	One Day or Less	750	Office				
	Two Days	751	Office				
	Three Days	752	Office				
	More than Three Days	753	Office				
	Overnight, Full Day Services	770	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number: _____ Cert Date: _____
☐ Perinatal Medi-Cal Number: _____ Cert Date: _____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From: _____ To: _____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence
(Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

Part III--Drug and Alcohol Services: Ancillary Services

RU Name: _____

Circle Days of Operation: S M T W TH F S

Hours of Operation: _____

Effective Billing Start Date: _____ **Effective Billing Stop Date:** _____

Place a check mark (√) to indicate services apply to this RU.

Ancillary

	Modality /Description of Service	Procedure Code(s)	Location (Circle applicable)	Min. Minutes	Max. Minutes	SFC	Contract Rate
	Acupuncture only	781	Office				
	Case Management (Ancillary)	782	Office				
	CM Assessment/ Screening(Ancillary)	783	Office Field				
	Ancillary CM Group	784	Office Field				
	TB Services	790	Office				
	HIV Services	791	Office				
	Perinatal Outreach	N/ A	Office Field				

FUNDING SOURCE

☐ DRUG Medi-Cal Number: _____ Cert Date: _____
☐ Perinatal Medi-Cal Number: _____ Cert Date: _____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From: _____ To: _____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence
(Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

Part III--Drug and Alcohol Services: Day Care Rehabilitative(DCR)

RU Name:_____

Circle Days of Operation: S M T W TH F S

Hours of Operation:_____

Effective Billing Start Date:_____ **Effective Billing Stop Date:**_____

Place a check mark (√) to indicate services apply to this RU.

Day Care Rehabilitative(DCR)

(√)	Modality /Description of Service	Procedure Code(s)	Location	Min. Minutes	Max. Minutes	SFC	Contract Rate
	Day Care Rehabilitative(DCR)-Non Medi-Cal	898	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number: _____ Cert Date: _____
☐ Perinatal Medi-Cal Number: _____ Cert Date: _____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From: _____ To: _____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence
(Enter 1, 2, 3 in the corresponding line below.)
___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

Part III--Drug and Alcohol Services: Drinking Diving Programs

RU Name:_____

Circle Days of Operation: S M T W TH F S

Hours of Operation:_____

Effective Billing Start Date:_____ **Effective Billing Stop Date:**_____

Place a check mark (√) to indicate services apply to this RU.

Drinking Driving Program

(√)	Modality /Description of Service	Procedure Code(s)	Location	Min. Minutes	Max. Minutes	SFC	Contract Rate
	DUI Education & Counseling	N/ A	Office				

FUNDING SOURCE

☐ DRUG Medi-Cal Number: _____ Cert Date: _____
☐ Perinatal Medi-Cal Number: _____ Cert Date: _____
☐ County/ State General Fund ☐ HIV Set Aside ☐ Prevention Set Aside
☐ Drug Court ☐ DDP ☐ BASN ☐ SACPA
☐ Work Order ☐ Private Pay

☐ Grant Name: _____
Grant Period: From: _____ To: _____

GRANT REQUIREMENT GUIDELINES

1. Grant Fund covers: ☐ Full cost ☐ Partial Cost
2. If Grant covers partial cost indicate the billing precedence (Enter 1, 2, 3 in the corresponding line below.)
   ___ Medi-Cal ___ General Fund ___ Grant
3. Grant applied to a _____ target population.
4. Other relevant information:

TARGET POPULATION

☐ Youth 12-17 ☐ Young Adult 18-29 ☐ Adult 30-54 ☐ Older Adult 55 and older
☐ Men ☐ Women ☐ Transgender FTM ☐ Transgender MTF
☐ Gay ☐ Lesbian ☐ Bisexual ☐ MSM ☐ Pregnant/ Postpartum
☐ Single Adult ☐ Women & Children/ Families
☐ Cultural/ Ethnic Groups _____ ☐ Languages _____
☐ Homeless ☐ Multi Diagnosis ☐ Criminal Justice Mandate ☐ Drug Specific (specify) _____
☐ Neighborhood (specify) _____ ☐ Other (specify) _____

Part IV--Attachments, Signatures and Distribution

Check off as attached:

_____CPT Code Crosswalk for providers who will be reimbursed on the basis of claims submitted on HCFA1500 (MHS only).

_____CRDC Worksheet (MHS only)

_____Contract Budget Summary (DAS only)

_____Fire clearance certificate (required for all new Organizational Providers)

_____NPI notification letter (National Provider Identifier - mandatory starting 1/2007)

_____ Medicare Provider Certification Letter (MHS only)

Please note:
Provider information or other circumstances for the Reporting Unit that may affect billing, for examples; the RU is County-funded thru a Work Order, Client services are funded by a Grant, Clients served are a Special Population or eligibility category, the RU is for tracking purposes only and no services will be entered, etc. Please attach supporting documents when appropriate or other pertinent information related to BIS set-up for these special circumstances.

Reporting Unit Notes:

_____

_____

_____

Signatures

☐ Signature signifies approval of **New or Changes** in Provider information contained on this form:

_____
Completed by CBHS Program Manager (Monitor) Date

_____
Approved by Age Director or SOC Services Director Date

_____
Approved by Assistant Director, for SOC Contract Coordination Date

Distribution List

1. BHBIS, 1380 Howard St., 3rd Floor, Pat Reynolds (**MHS**), Estifanos Tsegay (**DAS**)
2. Program Review, Compliance & Performance, 1380 Howard St., 4th Floor, Carlos Balladares
3. Data Manager, 1380 Howard St., 2nd Floor, Jose Castro
4. Compliance & Performance, 1380 Howard St., 2nd floor, Jim Gilday
5. Manager, Contracts Unit, 1380 Howard St., 4th Floor (only if the Provider is a contractor).
6. Fiscal Cost Reports, 101 grove St. Room 110, Annabel Martinez
7. BHIS, 1380 Howard St., 3rd Floor, Nan Dame
8. Children's Programs, 1380 Howard St., 5th floor, Philip Tse
9. Adult & Older Adult, 1380 Howard St., 5th floor, Shirley Giang
10. Contract Compliance, 1380 Howard St., 4th floor, Duane Einhorn
11. Other Program Managers and lead Contract Administrator as listed on this form
12. CBHS Program Manager or Contract Monitor retains a file copy
13. Quality Management Unit, 1380 Howard St., 5th Floor (Provider database)
14. Billing Unit, 1380 Howard St., 3rd Floor, Chi Phan (for Medicare billing as a payor source)