STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

GOOD CAUSE CERTIFICATION

_____ requests a waiver of the 30-day Drug Medi-Cal billing limitation for the claims listed below.
COUNTY/DIRECT PROVIDER

Delay Reason Code: _____

EDI File Name: _____

CLAIM SUBMITTER'S IDENTIFIER	CLAIM FOR MO/YR	CLAIM SUBMITTER'S IDENTIFIER	CLAIM FOR MO/YR

Signature: COUNTY/DIRECT PROVIDER REPRESENTATIVE

Date:

Phone Number
( )

STATE USE ONLY

REVIEWED AND APPROVED FOR DELAY REASON CODES 4 AND 11

Analyst Name: _____

Signature: DHCS - FMAB-SUD MANAGER