STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

MULTIPLE BILLING OVERRIDE CERTIFICATION

PROVIDER NAME: _____

CLIENT NAME: _____

MONTH/YEAR OF SERVICES CLAIMED: _____

CIN: _____

Please complete this certification form for multiple services provided to a client for the same day.

SERVICE FACILITY LOCATION NPI	ZIP CODE+4 (if applicable)	SERVICE DATE	UNITS BILLED	SERVICE TYPE	OVERRIDE REASON*

*OVERRIDE REASON:

1) The client could not receive all necessary services at one time. The client record clearly documents the date and time of day each visit was made and that the return visit was not a hardship on the client.

2) Crisis visit. Services are documented in client record.

3) Collateral services. Services are documented in client record.

I hereby certify that I am authorized to represent the provider. I further certify that I have reviewed the client record specified above and have determined that the services billed were necessary and in compliance with Title 22, Section 51490.1.

Signature: PROVIDER REPRESENTATIVE	Date

TITLE

RETAIN THE ORIGINAL CERTIFICATION IN THE CLIENT FILE. THIS DOCUMENT MUST BE PRODUCED ON DEMAND FOR AUDIT OR SITE VISIT BY DHCS