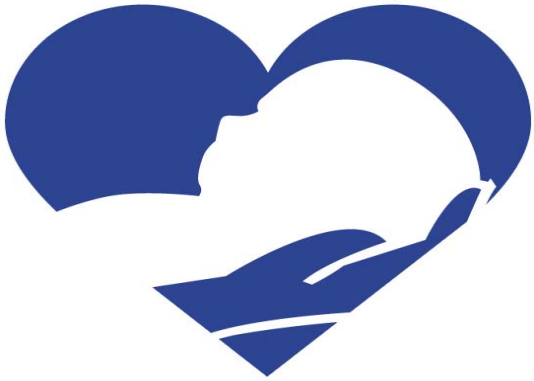
California Newborn Hearing Screening PROGRAM



Provider Manual

Department of Health Care Services
Children's Medical Services

Table of Contents

SECTION 1.0 - GENERAL INFORMATION

Introduction - How To Use This Manual

The Newborn Hearing Screening Program (NHSP) Provider Manual has been prepared by the Department of Health Care Services, Children's Medical Services (CMS). This manual addresses the specific program policies, billing codes and procedures for completing claims for NHSP services and diagnostic hearing evaluation services rendered to newborns and infants by eligible providers.

The manual is intended to be used in conjunction with the Medi-Cal Provider Manual and the monthly Medi-Cal Update bulletins.

SECTION 1.1 - NEWBORN HEARING SCREENING PROGRAM

Background

The California Newborn Hearing Screening Program (NHSP) was established as a result of Assembly Bill 2780, Chapter 310, Statutes of 1998. This law requires the establishment of a comprehensive hearing screening program for the early detection of hearing loss in newborns and infants, with access to diagnostic evaluations and follow-up services, and provisions for data collection and reporting. The Department of Health Care Services (DHCS), specifically the Children's Medical Services (CMS), has responsibility for the implementation and oversight of this program.

Prior to the NHSP, only infants receiving care in a California Children's Services (CCS)-approved neonatal intensive care unit (NICU) who were at "high risk" for deafness were screened for hearing loss. Follow-up services for the infants identified with a hearing loss were provided through the CCS High-Risk Infant Follow-up Program.

Now, all hospitals with licensed perinatal services are required to develop and administer their own hearing screening program for newborns and infants born in the hospital or receiving care in the intensive care nursery (ICNN)/NICU. California has over 550,000 births per year. More infants than ever before will receive a hearing screen. It is anticipated that the NHSP will result in the identification of an estimated 1,100 newborns and infants born each year with a significant hearing loss who will be linked with appropriate follow-up and early intervention services.

Program Overview

The NHSP is a comprehensive and coordinated system of early identification, tracking and monitoring of hearing screening, access to diagnostic services, and coordination of appropriate intervention and support services for newborns and infants with hearing loss. The goal of the program is to identify newborns and infants with a hearing loss prior to three months of age and to implement audiological and early intervention services by six months of age.

Under the NHSP, all hospitals with licensed perinatal services are required to provide inpatient hearing screening for all newborns, with the parent's permission, prior to hospital discharge. All infants receiving care in an ICNN/NICU must receive inpatient infant hearing screening services prior to discharge. Inpatient infant hearing screening includes a repeat hearing screen prior to discharge if the newborn or infant did not pass the initial inpatient hearing screening.

Newborns and infants who do not pass the inpatient infant hearing screening are referred to an outpatient infant hearing screening provider for hearing rescreening that should be performed within one month of discharge. Newborns and infants who were discharged from the birthing hospital before inpatient infant hearing screening services were provided will be referred to an outpatient infant hearing screening provider. Providers who can be certified as outpatient infant hearing screening providers include: NHSP-certified inpatient infant hearing screening providers; CCS-approved Type A, B, and C Communication Disorder Centers and CCS-paneled audiologists, pediatricians, otolaryngologists, and family practice physicians.

Newborns and infants who do not pass the outpatient initial hearing screening or the outpatient hearing rescreening are referred to a CCS-approved Type C Communication Disorder Center for a diagnostic hearing evaluation and to the local CCS program for authorization of this evaluation.

Upon identification of a hearing loss, infants and their families are referred to the local Early Start Program for access to early intervention and related services. The results of the diagnostic hearing evaluation are sent to the local CCS program so that eligibility for the program's treatment services can be determined. Subsequent to the eligibility determination, on-going audiologic services including habilitation and amplification, if chosen by the family, can be authorized.

A vital part of the NHSP is the exchange of information throughout the hearing screening process. Families will be provided informational materials that are related to the screening process, including the results of the screening. Primary care providers will receive the results of the screenings and diagnostic evaluations of infants under their care. The hospital will provide information and continuing education to medical and nursing staff regarding hearing screening.

In addition to hearing screening services, the NHSP has several other components. These include:

- Hearing Coordination Centers (HCCs) which assist hospitals in developing their screening programs, certify and monitor the screening programs, and track those infants who require further screening and intervention to assure that they are linked to appropriate services. Each HCC has a geographic service area for which it is responsible.

- Data collection, tracking and management.

The NHSP does not mandate a specific technology to perform the newborn hearing screening in the well baby nursery. Evoked potential or otoacoustic emission testing instruments approved by the Food and Drug Administration (FDA) that detect a mild hearing loss in a newborn or infant are acceptable. Because of the elevated risk of auditory neuropathy/dys-synchrony, newborns receiving care in the ICNN/NICU must be screened using FDA-approved auditory brainstem response (ABR) screening technology and must be referred to an outpatient screening provider that uses ABR screening equipment. However, infants receiving care in the ICNN/NICU who are greater than six months corrected age must be referred to a Type C Communicaton

Disorder Center or equivalent facility approved by the infant's insurance for a complete diagnostic evaluation.

Reimbursement is available from Medi-Cal for hearing screening services provided to newborns and infants eligible for the program or from the CCS program for newborns who are uninsured. Providers who have been certified to provide newborn hearing screening services may submit claims for services in accordance with the procedures outlined in this manual.

For purposes of the NHSP, "uninsured" means that the newborn or infant had no evidence of health insurance:

1. For the hospital stay during which the inpatient hearing screening was performed.

2. At the time the outpatient hearing screening or rescreening was performed.

Certification - What It Means

Inpatient Infant Hearing Screening Providers

All hospitals with licensed birthing facilities and all hospitals with an ICNN/NICU must develop their own inpatient hearing screening program based on the standards described in Chapter 3.42.1 of the CCS Manual of Procedures. The standards address many areas such as:

- Staffing, including competency testing of individuals conducting the hearing screening
- Facility requirements, including the use of appropriate newborn hearing screening equipment
- Services, including information distribution to parents and primary care providers
- Care coordination and referral
- Data collection and reporting

Hospitals that are in compliance with these standards will be certified as inpatient infant hearing screening providers. Certification allows providers to bill the Medi-Cal and CCS programs for hearing screening services provided on or after the effective date of certification and in accordance with the guidelines contained in this manual.

The certification process is conducted by the HCC serving the geographic service area in which the hospital is located.

Outpatient Infant Hearing Screening Providers

To participate in the NHSP, outpatient providers of hearing screening services must be certified as being in compliance with the standards described in Chapter 3.42.2 of the CCS Manual of Procedures. Certified outpatient providers will be able to bill the Medi-Cal or CCS programs for eligible newborns and infants who received hearing screening services on or after the effective date of certification. The certification process for outpatient infant hearing screening providers is conducted by CMS staff.

SECTION 1.2 - REIMBURSEMENT REQUIREMENTS

Prior Authorization

Prior authorization **IS NOT REQUIRED** for inpatient or outpatient infant hearing **SCREENING OR RESCREENING** services.

Prior authorization **IS REQUIRED** for **DIAGNOSTIC HEARING EVALUATIONS**. For information regarding prior authorization requirements for diagnostic hearing evaluations, please refer to the section in this manual titled "Referral For Hearing Diagnostic Evaluation".

Procedure Codes

Claims for reimbursement must include the appropriate procedure code listed on the following pages when billing for newborn hearing screening services.

Reminder:	Prior to rendering services and submitting a claim, providers are responsible for determining what hearing screening services the newborn or infant may have already received.

PROCDURE CODE Z7925

Procedure Code	Description	Policy
Z9725	Initial Infant Hearing Screening - Hospital/Inpatient	(1) Used to bill for hearing screening services provided to: • Newborns during their birth admission in a NHSP-certified hospital; • Newborns or infants receiving care in a CCS-approved NICU in an NHSP-certified NICU; • Newborns or infants transferred to an NHSP-certified hospital from another hospital who did not receive a hearing screening prior to the transfer. (2) Initial inpatient infant hearing screening is complete when the newborn or infant: • Passes the first bilateral screening; • Does not pass the initial screening in one or both ears but passes the repeat screening in both ears; or • Does not pass the initial and repeat screening in one or both ears. (3) Includes the repeat hearing screening performed as part of the initial inpatient hearing screening service during the newborn's or infant's admission to the hospital. (4) Payable on a fee-for-service basis **ONLY** to NHSP-certified hospitals. This service is not included in the capitation rate paid to Medi-Cal Managed Health Care Plans or in the negotiated hospital reimbursement paid to hospitals participating in the Selective Provider Contracting Program. (5) Payable once per hospital for the same newborn or infant. (6) Claims with dates of service for initial inpatient infant hearing screening performed after the infant is 12 months of age are not payable. (7) Claims are only payable for dates of service on or after the effective date of the provider's certification under the NHSP.

PROCEDURE CODE Z9726

Procedure Code	Description	Policy
Z9726	Initial Infant Hearing Screening - Outpatient	(1) Used to bill for hearing screening services provided by outpatient infant hearing screening providers. (2) Used to bill for those infants born in a CCS-approved hospital or receiving care in a CCS-approved NICU who were discharged from the hospital before initial inpatient hearing screening services were offered or provided. (3) Initial outpatient infant hearing screening is complete when the newborn or infant: • Passes the initial outpatient screening in both ears; or • Does not pass the initial outpatient screening in one or both ears. (4) Payable on a fee-for-service basis **ONLY** to NHSP-certified providers. This service is not included in the capitation rate paid to Medi-Cal Managed Health Care Plans. (5) Payable **ONLY** if procedure code Z9725 has not been billed. (6) Claims with dates of service for initial outpatient infant hearing screening performed after the infant is 12 months of age are not payable. (7) Claims are only payable for dates of service on or after the effective date of the provider's certification under the NHSP.

PROCUDERE CODE Z9727

Procedure Code	Description	Policy
Z9727	Infant Hearing Rescreening - Outpatient	(1) Used to bill for hearing screening services provided by outpatient infant hearing screening providers. (2) Used to bill for those newborns or infants who did not pass the initial inpatient infant hearing screening in one or both ears. (3) Rescreening is complete when the newborn or infant: • Passes the outpatient hearing rescreening in both ears; or • Does not pass the outpatient hearing rescreening in one or both ears. (4) Payable on a fee-for-service basis **ONLY** to NHSP-certified providers. This service is not included in the capitation rate paid to Medi-Cal Managed Health Care plans. (5) Payable only once for the same newborn or infant, regardless of eligible provider. (6) Not payable if procedure code Z9726 has been paid. (7) Claims with dates of service for outpatient infant hearing rescreening performed after the infant is 12 months of age are not payable. (8) Claims are only payable for dates of service on or after the effective date of the provider's certification under the NHSP.

SECTION 1.3 - BILLING

Proper and timely submission of claims is of the highest importance. Delayed or improperly prepared claims could result in delayed payment or possible denial. Providers billing for patients who are Medi-Cal eligible or who are uninsured must adhere to the following specific instructions when completing the claim form and other applicable instructions described in the Medi-Cal Provider Manual.

Provider Number

For billing NHSP services rendered to Medi-Cal eligible newborns and infants, providers must use their outpatient Medi-Cal NPI provider number **and submit the claims to EDS**.

For billing NHSP services rendered to uninsured newborns and infants, providers must use their outpatient NPI number **and submit the claims to the Children's Medical Services.**

Please note that providers are responsible for ensuring that their Medi-Cal provider account/NPI number information is correct and remains current with the Medi-Cal Program and this office. Failure to maintain current Medi-Cal provider account/NPI information can result in denied claims for reimbursement.

Reminder: Providers who wish to change the Medi-Cal outpatient provider number that they are using to bill inpatient or outpatient hearing screening services must send a written request to:

Attn: Program Manager
Hearing & Audiology Services Unit
Children's Medical Services
Department of Health Care Services
P.O. Box 997413 MS 8102
Sacramento, CA 95899-7413

Claim Forms

Providers are required to bill for services on the appropriate claim forms. Listed below are the forms to be used by procedure code. Examples of completed claim forms are located in the Appendix of this manual.

Procedure Code	Claim Form	Provider Number
Z9725	**UB-04**	• Hospital outpatient Medi-Cal NPI number • Los Angeles County Waiver hospitals use Medi-Cal "LAW" provider prefix
Z9726	***CMS 1500**	Outpatient Medi-Cal NPI number
Z9727	***CMS 1500**	Outpatient Medi-Cal NPI number

*** Exception: Hospitals must ALWAYS use the UB-04 claim form whether they are billing for inpatient or outpatient NHSP services. All other NHSP outpatient providers must use the CMS 1500 claim form for billing for NHSP outpatient services.**

UB-04 Claim Form – Requirements for Completion

Box 4, Type of Bill:

- Enter the appropriate 3-digit number. Refer to the Medi-Cal Provider Manual to determine the correct number to enter. (Note: The NHSP example claim forms in the Appendix of this manual show the number "123" in box 4 as an example only.)

Box 50, Payer:

- Enter "O/P MEDI-CAL."

Box 58, Insured's Name

- Fill in only If billing for an infant using the mother's ID, enter the Medi-Cal recipient's name here and the patient's relationship to the Medi-Cal recipient in Box 59.

- Leave blank if not billing for an infant using mother's ID.

Box 59, Patient's Relationship to Insured

- Enter "03" Only if billing for an infant using the mother's ID
- Leave blank if not billing for an infant using mother's ID

Box 84, Remarks:

- For inpatient infant hearing screening services (Procedure Code Z9725), enter "Newborn Hearing Screening Program. This service is not included in the facility contracted rate."
- For outpatient infant hearing screening services (Procedure Codes Z9726 and Z9727), enter "Newborn Hearing Screening Program."

Box 50, Place of Service

- For CMS 1500 forms, complete the Place of Service field, box 24B. Our example claim forms in the Appendix of this manual are for a physician's office, therefore "11" is entered in the Place of Service field. For other place of service codes, please refer to the Medi-Cal Provider Manual.
- For UB-04 forms, enter "O/P MEDI-CAL" in box 50.

Los Angeles County (LAC) Waiver Hospitals

LAC Waiver Hospitals that are NHSP-certified must use the provider number prefix "LAW" when billing for the inpatient or outpatient hearing screening procedure codes listed above. This prefix is assigned by the Department when NHSP provider certification is approved and is limited to billing for NHSP services. All other billing instructions stated in this manual and the Medi-Cal Provider Manual apply to LAC Waiver Hospitals.

Reimbursement Rate

The reimbursement rate of $30.00 is payable for procedure codes Z9725, Z9726 and Z9727 in accordance with the guidelines described in this manual. The rate includes all technical and professional components of the screening procedure, related patient management, information management and documentation.

Where to Submit Claims

Claims adjudication for inpatient and outpatient hearing screening services vary based on the following:

1. Claims for newborns and infants eligible under the Medi-Cal program are submitted to EDS. Refer to the Medi-Cal Provider Manual for submission instructions.

2. Claims for uninsured newborns and infants are submitted to the office listed below. Prior to submission, the provider must verify that, to the best of their knowledge, the newborn or infant is uninsured as defined under the NHSP (see page 4 of this manual for the definition). Send the claim to:

Attn: Program Manager
Department of Health Care Services
Children's Medical Services
Hearing & Audiology Services Unit
MS 8103
P.O. Box 997413
Sacramento, CA 95899-7413

SECTION 2.0 - REFERRAL FOR DIAGNOSTIC HEARING EVALUATION

Background

The CCS program is responsible for providing diagnostic services to determine the presence of a CCS-eligible condition when there is a suspicion that one exists. Hearing loss is a CCS-eligible condition and is suspected when a newborn or infant does not pass the hearing screening as defined by the NHSP. Diagnostic services are available from CCS-approved providers regardless of family income; however, the CCS program requires that families use third-party insurance coverage first before CCS funds are expended. Please see the next page for the specific information to follow regarding prior authorizaton requirements.

Newborns or infants who do not pass the initial outpatient hearing screening or outpatient hearing rescreening are referred to a CCS-approved Type C Communication Disorder Center for the diagnostic hearing evaluation.

Scheduling the Appointment

It is the goal of the NHSP to identify the presence of hearing loss by three months of age. Therefore, the appointment for the diagnostic hearing evaluation should be scheduled as soon as possible after the newborn or infant does not pass the initial outpatient hearing screening or the outpatient hearing rescreening.

The parents should be assisted in scheduling the appointment. This may be done by the provider who will be performing the diagnostic hearing evaluation, the provider who is making a referral for the evaluation or the hospital.

The appointment can be scheduled simultaneously with the submission of the request for prior authorization to the appropriate CCS Program Office.

What the Diagnostic Hearing Evaluation Includes

The diagnostic hearing evaluation includes the audiologic testing procedures necessary to determine the type, degree and configuration of hearing loss. The evaluation appointment is typically scheduled for one to two hours and may require more than one visit to complete all the testing.

SECTION 2.1 - REIMBURSEMENT REQUIREMENTS

Prior Authorization

Prior authorization is required for the diagnostic hearing evaluation just as it is for all diagnostic and treatment services covered by the CCS program.

The CCS program will respond to a request for prior authorization within five working days of receipt of the request. The authorization will be issued to a CCS-approved Type C Communication Disorder Center for all newborns and infants referred through the NHSP.

Reminder	The CCS program will authorize the diagnostic hearing evaluation regardless of the health insurance status of the newborn or infant. The provider who will be performing the evaluation must simultaneously request prior authorization from the private health insurance carrier for newborns and infants who have such insurance. However, a denial from the insurance carrier is **NOT** required prior to requesting authorization from the CCS program.

Prior Authorization Documents Required

Providers must send the following information by mail or facsimile to the CCS program in the county where the child resides:

- An "Application to Determine CCS Program Eligibility" form completed and signed by the family, unless one was submitted by the referring provider.
- A completed "Service Authorization Request (SAR) (DHCS 4488)" form or a CCS NHSP Request for Service form (NHSP 400-1). Please Note: The use of the SAR (DHS 4488) form is strongly encouraged.
- A copy of the hearing screening results.

If providers are referring the newborn or infant to a different facility for the diagnostic hearing evaluation they must indicate the name of the provider to whom the child is being referred.

Copies of the above mentioned CCS forms are included in the Appendix section of this manual and are available on-line at www.dhcs.ca.gov/services/nhsp/Pages/NHSPFORMS

SECTION 2.2 - BILLING

Procedure Codes

Providers should refer to the Medi-Cal Provider Manual for the appropriate procedure codes to use for billing diagnostic hearing evaluation services. The current reimbursement rates assigned to these procedure codes will apply to claims for these services.

Claim Forms

Providers should refer to the Medi-Cal Provider Manual for the appropriate claim form to use and instructions on how to complete it.

Where to Submit a Claim

Claims for diagnostic hearing evaluation services provided to newborns and infants which are authorized by the CCS program must be submitted in accordance with the instructions in the Medi-Cal Provider Manual.

Claims for diagnostic hearing evaluation services provided to newborns and infants who are not Medi-Cal eligible and who have private health insurance must be submitted to the insurance carrier prior to billing the CCS program. A denial of payment from the insurance carrier must accompany the claim submitted to CCS in order for CCS to pay the claim.

SECTION 3.0 - BILLING QUESTIONS

Where to get Assistance

For assistance in resolving policy or program matters related to the NHSP or in completing claims for hearing screening for uninsured children, providers should contact the California NHSP at 1-916-322-5794 or toll-free at 1-877-388-5301.

For assistance in completing Medi-Cal claims and all other Medi-Cal billing matters, providers should contact EDS at 1-800-541-5555.

Providers **SHOULD NOT** contact the Hearing Coordination Center with billing questions.

APPENDIX

Examples of completed claim forms:

- Medi-Cal Beneficiary – Inpatient Screening (UB-04)
- Uninsured – Inpatient Screening (UB-04)
- Medi-Cal Beneficiary – Outpatient Screening (CMS-1500)
- Medi-Cal Beneficiary – Outpatient Screening Provided by a Hospital (UB-04)
- Uninsured – Outpatient Screening (CMS-1500)
- Uninsured – Outpatient Screening Provided by a Hospital (UB-04)

Forms:

For the most current form, please click on the links.

- * Application to Determine CCS Program Eligibility, DHCS 4480 - English
  * Application to Determine CCS Program Eligibility, DHCS 4480 - Spanish

- **New Referral CCG/GHPP Client Service Authorization Request (SAR), DHCS 4488

- **Established CCS/GHPP Client Service Authorization Request (SAR), DHCS 4509

- * CCS Request for Service Form, Newborn Hearing Screening Program Referral NHSP 400-1

- * Hearing Coordination Center Directory

- *** State Office Directory

- ** County CCS Office Directory

*Available at: www.dhcs.ca.gov/services/nhsp

** Available at: www.dhcs.ca.gov/services/ccs

*** Available at: www.ca.gov

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT		41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
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21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

80 REMARKS	81CC			
	a			
	b			
	c			
	d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

	31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a							a
b							b

38		39 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
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22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
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a							a
b							b

38		39 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

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23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

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A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT		41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		**TOTALS**				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

80 REMARKS	81CC			
	a			
	b			
	c			
	d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

Place Holder - Sample CMS 1500 Claim Forms will be added when finalized – Check back for this item at a later date.

INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form **or** whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income; or the child has Healthy Families coverage.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost; or
- have Healthy Families coverage.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

- complete the application form on page 3 and return it to their county CCS office;
- give CCS all of the information requested so CCS can determine if the family qualifies;
- apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

- CCS must keep this information confidential.[2]
- CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes

1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term **"applicant"** means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by

2. Date of birth (month, day, year)	3. Place of birth—county and state	Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. box)	City	County	ZIP code

5. Gender ☐ Male ☐ Female	6. Race/ Ethnicity	7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Name of applicant's physician	10. Physician's phone number ( )

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name

13. Residence address (number, street) (do not use a P.O. box)	City	County	ZIP code

14. Mailing address (if different from 13)	City	ZIP code

15. Day phone number ( )	16. Evening phone number ( )	17. Message phone number ( )	18. What language do you speak at home?

C. Health Insurance Information

19. Does the applicant have Medi-Cal? ☐ Yes ☐ No	If yes, what is the applicant's Medi-Cal number?	Is there a share-of-cost? ☐ Yes ☐ No	If yes, what amount do you pay per month? $

20. Is the applicant enrolled in the Healthy Families program? ☐ Yes ☐ No	If yes, what is the name of the plan?

21 Does the applicant have other health insurance? ☐ Yes ☐ No	If yes, what is the name of the insurance plan or company?

Type of insurance plan or company

☐ Preferred Provider (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other:_____

22. Does the applicant have dental insurance? ☐ Yes ☐ No	23. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

☐ I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program.

☐ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

☐ I certify that I have read and understand the information or have had it read to me.

☐ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date

Signature of witness (only if the person signed with a mark)	Date

Mail this form to your county CCS office.

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office (see page 6). Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. box.
5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

   - Alaskan Native
   - Amerasian
   - American Indian
   - Asian
   - Asian Indian
   - Black/African American
   - Cambodian
   - Chinese
   - Filipino
   - Guamanian
   - Hawaiian
   - Hispanic/Latino
   - Japanese
   - Korean
   - Laotian
   - Samoan
   - Vietnamese
   - White
   - Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write down the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Daytime phone number:** Please write the phone number where you can be reached during the day.
16. **Evening phone number:** Please write the phone number where you can be reached during the evening.
17. **Message phone number:** Please write your message phone number if applicable.
18. **Language(s) spoken:** Write down the language you speak **at home**.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

19. If the applicant does not receive Medi-Cal, check "No" and go to number 20. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes" and fill in the amount of your shared cost. If you don't, check "No" and go to number 20.
20. If the applicant receives health insurance from the Healthy Families program please check "Yes" and fill in the name of the plan. If the applicant does not, check "No." Healthy Families is a special health insurance program for moderate to low income families. If you think you might qualify, you can ask your county CCS program about how to apply for the Healthy Families program.
21. If the applicant does not have other health insurance, check "No" and go to number 22. If the applicant has health insurance, check "Yes" and fill in the name of the insurance plan or company. Then check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.
22. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."
23. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

INSTRUCTIONS

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Gender: Check the appropriate box.
10. Date of birth: Enter the client's date of birth.
11. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
12. Client index number (CIN): Enter the client's CIN number. If not known, leave blank.
13. Client's Medi-Cal number: Enter the client's Medi-Cal number. If number is not known, leave blank.

Diagnosis

14. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

15. a. CCS/GHPP New SAR: Check if requesting a new authorization for an established CCS/GHPP client.
    b. Authorization extension: Check if requesting an extension of an authorized request. Please enter the authorization number on the line.
16. CPT-4/HCPCS code/NDC: Enter the requested CPT-4, HCPCS code, or NDC code. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
17. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
18. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
19. Frequency/duration: Enter the frequency or duration of the procedures/services being requested.
20. Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
21. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
22. Other documentation attached: Check this box if attaching additional documentation.
23. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

24. Begin date: Enter the date the requested inpatient stay will begin.
25. End date: Enter the date the requested inpatient stay will end.
26. Number of days: Enter the number of days for the requested inpatient stay.
27. Extension begin date: Enter the date the requested extension of authorized inpatient stay will begin.
28. Extension end date: Enter the date the requested extended stay will end.
29. Number of extension days: Enter number of days for the requested extension inpatient stay.

Additional Services Requested from Other Health Care Providers

30. and 31. Provider's name: Enter name of the provider you are referring services to.
    Provider number: Enter the provider's provider number.
    Telephone: Enter provider's telephone number.
    Contact person: Enter the name of the person who can be contacted regarding the request.
    Address: Enter address of the provider.
    Description of services: Enter description of referred services.
    Procedure code: Enter the procedure code for requested service other than ongoing physician services.
    Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
    Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
    Additional information: Include any written instructions/details here.

Signature

32. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
33. Date: Enter the date the request is signed.

ESTABLISHED CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last | First | Middle

9. Gender ☐ Male ☐ Female	10. Date of birth (mm/dd/yyyy)	11. CCS/GHPP case number

12. Client index number (CIN)	13. Client's Medi-Cal number

Diagnosis

14. Diagnosis (DX)/ICD-9: _____ DX/ICD-9: _____ DX/ICD-9: _____

15. Service Authorization Request for *(Check one)*

☐ a. CCS/GHPP New SAR

☐ b. Authorization extension (If checked, enter authorization number: _____)

Requested Services

16.* CPT-4/ HCPCS Code/NDC	17. Specific Description of Service/Procedure	18. From (mm/dd/yy)	To (mm/dd/yy)	19. Frequency/ Duration	20. Units	21. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 16 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

22. Other documentation attached ☐ Yes	23. Enter facility name (where requested services will be performed, if other than office.

Inpatient Hospital Services

24. Begin date	25. End date	26. Number of days	27. Extension begin date	28. Extension end date	29. Number of extension days

Additional Services Requested from Other Health Care Providers

30. Provider's name | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Units | Quantity

Additional information

31. Provider's name | Medi-Cal provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Units | Quantity

Additional information

32. Signature of physician/provider or authorized designee	33. Date

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number	7. Contact fax number
	( )	( )

Client Information

8. Client name—last | first | middle

9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)

12. CCS/GHPP case number	13. Contact phone number	14. Medical record number (hospital or office)
	( )	

15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

17. County of residence	18. Language spoken	19. Name of parent/legal guardian

20. Mother's first name	21. Primary care physician (if known)	22. Primary care physician telephone number
		( )

Insurance Information

23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	23.b. Client index number (CIN)	23.c. Client's Medi-Cal number

24. Enrolled in Healthy Families? ☐ Yes ☐ No	If yes, name of plan

25. Enrolled in commercial insurance plan? ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

26. Diagnosis (DX)/ICD-9:_____ DX/ICD-9:_____ DX/ICD-9:_____

Requested Services

27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure	29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units	32. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

33. Other documentation attached ☐ Yes	34. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

35. Begin date	36. End date	37. Number of days

Additional Services Requested from Other Health Care Providers

38. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity
Diagnostic Audiologic Evaluation	**SCG 04**		

Additional information

39. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity
Otolaryngology Evaluation	**SCG 01**		

Additional information

40. Signature of physician/provider or authorized designee	41. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Medi-Cal provider number: Enter Medi-Cal billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
13. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
14. Medical record number: Enter the client's hospital or office medical record number.
15. Residence address: Enter the address of the client. Do not use a P.O. Box number.
16. Mailing address: Enter the mailing address if it is different than number 15.
17. County of residence: Enter residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

23a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families?: Mark the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

26. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

27. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
28. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
29. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
30. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
31. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
32. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
33. Other documentation attached: Check this box if attaching additional documentation.
34. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

35. Begin date: Enter the date the requested inpatient stay shall begin.
36. End date: Enter the end date for the inpatient stay requested.
37. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

38. and 39. Provider's name: Enter name of the provider you are referring services to.
Medi-Cal provider number: Enter the provider's Medi-Cal provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

40. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
41. Date: Enter the date the request is signed.

Hearing Coordination Center Directory

Regions A and B

Bay Area/Northern California Hearing Coordination Center
3480 Buskirk Avenue, Suite 125
Pleasant Hill, CA 94523
E-mail: info@johnmuirhealth.com
Main Office: 925-941-7933
Fax: Region A Bay Area 925-947-4956
Region B Northern California 925-947-4957

Region C

Southern California Hearing Coordination Center
2801 Atlantic Avenue, Suite 202
Long Beach, CA 90806
E-mail: schcc@memorialcare.org
Main Office: 562-933-8152
Fax: 562-933-8157

Region D

South Eastern California Hearing Coordination Center
11234 Anderson Street, MVP-185
Loma Linda, CA 92354
E-mail: sechcc@llu.edu
Main Office: 909-558-3478
Fax: 909-558-3482

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Medi-Cal provider number: Enter Medi-Cal billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
13. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
14. Medical record number: Enter the client's hospital or office medical record number.
15. Residence address: Enter the address of the client. Do not use a P.O. Box number.
16. Mailing address: Enter the mailing address if it is different than number 15.
17. County of residence: Enter residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

23a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families?: Mark the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

26. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

27. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
28. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
29. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
30. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
31. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
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33. Other documentation attached: Check this box if attaching additional documentation.
34. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

35. Begin date: Enter the date the requested inpatient stay shall begin.
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37. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

38. and 39. Provider's name: Enter name of the provider you are referring services to.
Medi-Cal provider number: Enter the provider's Medi-Cal provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

40. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
41. Date: Enter the date the request is signed.

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number	7. Contact fax number
	( )	( )

Client Information

8. Client name—last | first | middle

9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)

12. CCS/GHPP case number	13. Contact phone number	14. Medical record number (hospital or office)
	( )	

15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

17. County of residence	18. Language spoken	19. Name of parent/legal guardian

20. Mother's first name	21. Primary care physician (if known)	22. Primary care physician telephone number
		( )

Insurance Information

23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	23.b. Client index number (CIN)	23.c. Client's Medi-Cal number

24. Enrolled in Healthy Families? ☐ Yes ☐ No	If yes, name of plan

25. Enrolled in commercial insurance plan? ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

26. Diagnosis (DX)/ICD-9:_____ DX/ICD-9:_____ DX/ICD-9:_____

Requested Services

27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure	29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units	32. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

33. Other documentation attached ☐ Yes	34. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

35. Begin date	36. End date	37. Number of days

Additional Services Requested from Other Health Care Providers

38. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity
Diagnostic Audiologic Evaluation	**SCG 04**		

Additional information

39. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity
Otolaryngology Evaluation	**SCG 01**		

Additional information

40. Signature of physician/provider or authorized designee	41. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Medi-Cal provider number: Enter Medi-Cal billing number (no group numbers).
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10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
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Additional information: Include any written instructions/details here.

Signature

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41. Date: Enter the date the request is signed.

CALIFORNIA CHILDREN SERVICES (CCS) PROGRAM
Request for Service Form
Newborn Hearing Screening Program (NHSP) Referral

This form is to be completed by a health care provider who is seeking approval for health care services (including hospital inpatient stays) from the CCS program for a potential CCS applicant or CCS client. When this is an initial request for services, it also constitutes a referral to the program. Items identified with an " * " and in **BOLD** denote required data fields which must be completed if further action is to be taken.

*** PATIENT INFORMATION** CCS Number (if known): _____ CIN No._____		**DATE:**
* **PATIENT'S NAME & ADDRESS**	*** DATE OF BIRTH**: / /	*** PARENT(S)/LEGAL GUARDIAN NAME & ADDRESS**
	GENDER: Male ☐ Female ☐	Sex
PATIENT'S BIRTH CERTIFICATE NAME (if different than name given)	SOCIAL SECURITY NUMBER: N/A	
PATIENT'S PLACE OF BIRTH (City, County and State) Delay	COUNTY OF RESIDENCE: Reason	*** HOME PHONE NUMBER: ( ) -** WORK PHONE NUMBER: ( ) -

MEDI-CAL? ☐ YES ☐ NO ☐ UNKNOWN If YES, NPI Number: If YES, is child in Managed Care Plan? ☐ YES ☐ NO If YES, Name of Plan: _____	MEDICAL INSURANCE? ☐ YES ☐ NO ☐ UNKNOWN If YES, Carrier or Plan Name and Policy Number: _____ Is Insurance an HMO? ☐ YES ☐ NO

HEALTHY FAMILIES: ☐ YES ☐ NO If YES, Name of Plan _____

Please complete the following two items below ONLY if this is the initial request for services for this patient.

*** MOTHER'S FIRST NAME AND MAIDEN NAME:**	*** ETHNIC GROUP:** ☐ Amer Indian ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Filipino ☐ Alaskan Native ☐ White ☐ Amer Asian ☐ Japanese ☐ Korean ☐ Samoan ☐ Chinese ☐ Cambodian ☐ Asian Indian ☐ Hawaiian ☐ Guamanian ☐ Laotian ☐ Vietnamese ☐ No Response ☐ Unknown

REQUEST FOR SERVICES

PROVIDER TYPE: ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER HEALTH CARE PROVIDER _____

SPECIFIC SERVICES REQUESTED PROCEDURE CODES

1. Diagnostic Hearing Evaluation
2.
3.

Attach pertinent medical information related to the request. (Describe nature of medical problems, including significant associated conditions OR attach medical reports that support the requested services)

If diagnosis is known, please identify:

PRIMARY: OTHER:

SECONDARY:

PROVIDER NAME/ADDRESS:

COMPLETED BY:	PHONE NUMBER: ( ) -

TITLE:

Hearing Coordination Center Directory

Regions A and B

Bay Area/Northern California Hearing Coordination Center
3480 Buskirk Avenue, Suite 125
Pleasant Hill, CA 94523
E-mail: info@johnmuirhealth.com
Main Office: 925-941-7933
Fax: Region A Bay Area 925-947-4956
Region B Northern California 925-947-4957

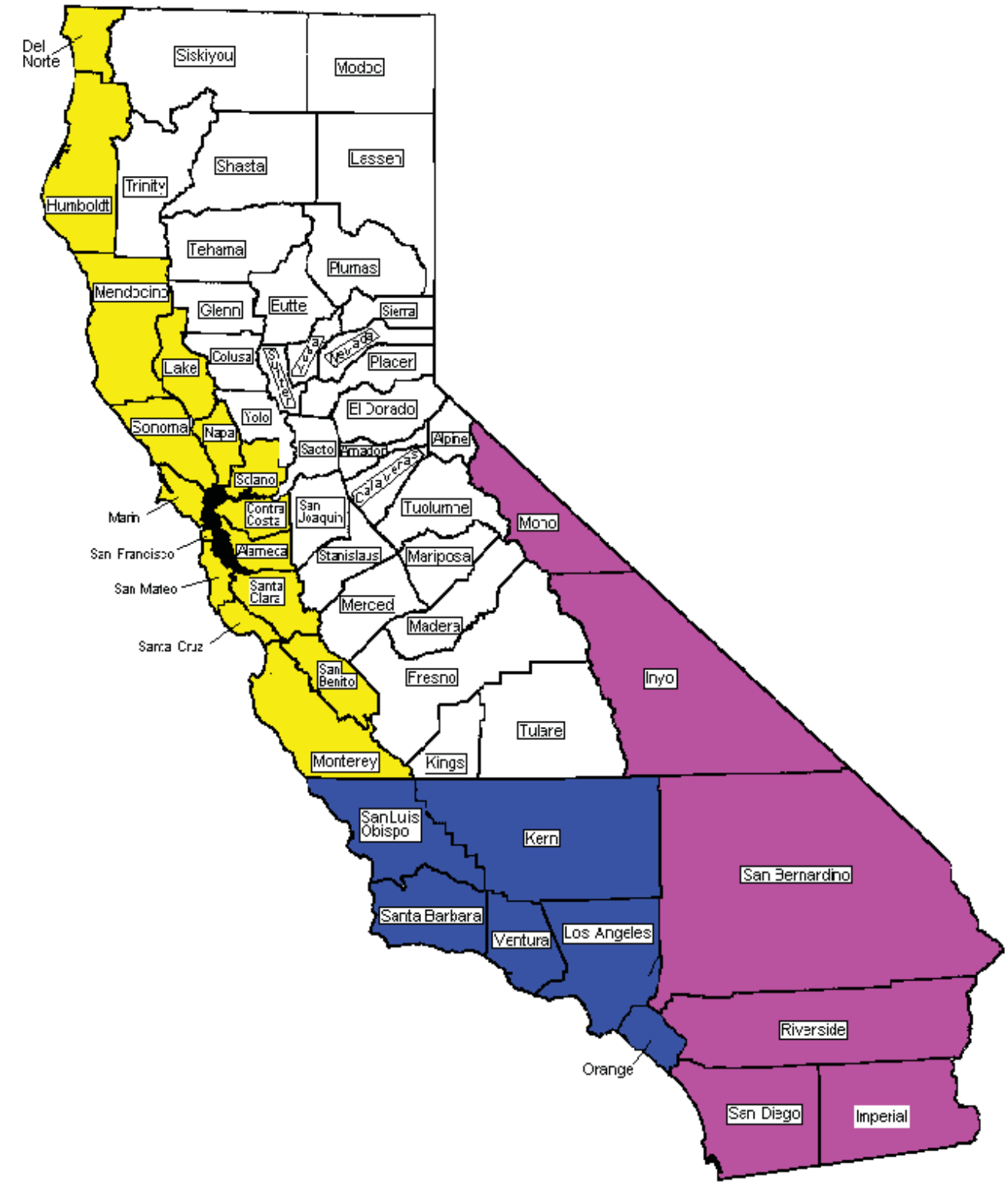
Region C

Southern California Hearing Coordination Center
2801 Atlantic Avenue, Suite 202
Long Beach, CA 90806
E-mail: schcc@memorialcare.org
Main Office: 562-933-8152
Fax: 562-933-8157

Region D

South Eastern California Hearing Coordination Center
11234 Anderson Street, MVP-185
Loma Linda, CA 92354
E-mail: sechcc@llu.edu
Main Office: 909-558-3478
Fax: 909-558-3482

California Newborn Hearing Screening Program
Hearing Coordination Center Geographical Service Areas



Region A – Bay Area/Northern California HCC – John Muir Health
Region B – Bay Area/Northern California HCC – John Muir Health
Region C – South-Eastern California HCC – Loma Linda University Medical Center
Region D – Southern California HCC - Miller Children's Hospital

State Regional Office Locations

Northern California Region

Northern California Region – Sacramento Office (NCRSO)
Program Manager
Children's Medical Services
P.O. Box 997413, MS 8105
Sacramento, CA 95899-7413
Main Phone: 916-327-3100
FAX: 916-327-0998 or 916-327-0653

Northern California Region – Oakland Office (NCRO)
Annette Irving, R.N.
Program Manager
1515 Clay Street, Suite 401
Oakland, CA 94612
Main Phone: 510-286-0757
FAX: 510-286-0743

Southern California Region

Southern California Regional Office (SCRO)
Susan Igdaloff, M.D.
Medical Consultant
311 South Spring Street, Suite 01-11
Los Angeles, CA 90013
Main Phone: 213-897-3574
FAX: 213-897-3501 or 213-897-2882

Southern California Regional Office
Linda Torn
Program Manager
311 South Spring Street, Suite 01-11
Los Angeles, CA 90013
Main Phone: 213-897-3574
FAX: 213-897-3501 or 213-897-2882

Children's Medical Services (CMS)
CCS Program Directory

Northern California Region – Sacramento Office
Program Manager
Children's Medical Services
P.O. Box 997413, MS 8105
Sacramento, CA 95899-7413
Main Phone: 916-327-3100
FAX: 916-327-0998 or
916-327-0653

Southern California Regional Office
Susan Igdaloff, M.D.,
Medical Consultant
Linda Torn, Program Manager
311 South Spring Street, Suite 01-11
Los Angeles, CA 90013
Main Phone: 213-897-3574
FAX: 213-897-3501 or 213-897-2882

Northern California Region – Oakland Office
Annette Irving, R.N.,
Program Manager
1515 Clay Street, Suite 401
Oakland, CA 94612
Main Phone: (510) 286-0757
FAX: (510) 286-0743

Genetically Handicapped Persons Program (GHPP)
MS 8200
P.O. Box 997413
Sacramento, CA 95899
Main Phone: 916-327-0470
Fax: 916-327-1112
Toll Free: 1-800-639-0597

The following table lists in alphabetical order the CCS county offices' mailing addresses telephone and fax numbers. It also identifies the county offices as dependent or independent, and the regional office responsible for the dependent county. This list is important in determining whether the CCS county office or the state CCS regional office must be contacted when requesting prior authorization. For the most current CCS Directory, please go to www.dhcs.ca.gov/services/ccs/Pages/countyoffices.aspx

The following guideline can be helpful in selecting the correct office:

- For questions on eligibility, prior authorization and submitting claims in independent counties, please contact the CCS independent county office.
- For residential or financial questions in dependent counties, please contact the CCS dependent county office.
- For medical eligibility questions in dependent counties, please contact the State CCS regional office.
- For questions on prior authorization or submitting claims in dependent counties, contact the appropriate State CCS Regional Office.

CCS County Office Directory

For the most current CCS County Office Directory, please go to:
www.dhcs.ca.gov/services/ccs/pages/countyoffices.aspx