DHCS | Medi-Cal Dental

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT PACKET

This enrollment packet consists of an EDI Provider Application/Agreement Form, an Option Selection Form, an ERA Enrollment Form, Title 22 and Forms Reorder Request. An EDI How-To Guide, which provides detailed information on electronic claims submission to the Medi-Cal Dental Program, should accompany this packet.

To submit documents electronically to the Medi-Cal Dental Program:

1. **Check with your vendor.**
   Contact your practice management system vendor for verification that your software includes the Medi-Cal Dental Program's EDI specifications.

2. **Complete the attached Application, Option Selection Form and ERA Enrollment Form.**
   Mail the Application **(all four pages),** Option Selection Form and, if electronic remittance data is desired, the ERA Enrollment Form to the following address. The EDI Support team will confirm your enrollment via letter.

   Medi-Cal Dental Program
   Correspondence
   P.O. Box 15609
   Sacramento, CA 95852-0609

   IMPORTANT: YOUR CLAIMS WILL BE REJECTED IF YOU ARE NOT ENROLLED AS AN EDI PROVIDER PRIOR TO SUBMITTING MEDI-CAL DENTAL CLAIMS ELECTRONICALLY.

3. **Order your EDI supplies directly from the supplier.**
   If radiographs or attachments are needed to process your claim or TAR, you can submit them conventionally or digitally. If you submit conventional radiographs, you will need to submit an EDI label attached to a specially marked envelope. Use the attached Forms Reorder Request to order a supply of all three types of envelopes (large and small x-ray envelopes, and large mailing envelopes) and one type of self-adhesive EDI label. These supplies are provided at no charge and are printed in red ink to identify them as related to EDI claims. (Note: Most Providers who use the services of a clearinghouse should order laser labels in the preprinted format #DC-018A, format B.)

4. **Enter & transmit claims to the Medi-Cal Dental Program.**
   Your practice management system vendor will advise you how to use your computer to submit your Medi-Cal Dental claims electronically.

5. **Retrieve your reports and labels each workday.**
   Follow your software vendor's instructions. Depending on how your system is linked to the Medi-Cal Program, you may receive your reports and labels through a clearinghouse. Please check for reports daily. Even if you did not submit any EDI claims the prior workday, you may have Notices of Authorization (NOAs) and/or Resubmission Turnaround Documents (RTDs waiting to be retrieved, if your system is set up to receive them electronically.

Note: Orthodontic treatment plans cannot be transmitted electronically and must be mailed to Medi-Cal Dental. However, diagnostic services associated with orthodontic treatment can be submitted electronically.

If you have any questions, please call:
Provider Services Toll-Free at (800) 423-0507
or EDI Support at (916) 853-7373 (email: medi-caldentaledi@delta.org)

MEDI-CAL DENTAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT
(For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, California Department of Health Care Services, hereinafter referred to as the "Department" and:

PROVIDER INFORMATION			
Provider name (full legal)			
Business Name (if applicable)	National Provider Identifier (NPI)		
Provider service address (number, street)	City	State	ZIP Code
Contact person	Email Address		
Contact person address (number, street)	City	State	ZIP Code
Contact telephone number ( )	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
BILLER INFORMATION (If other than the provider of service)			
Biller name (full legal)	Biller telephone number ( )		
Business Name (if applicable)	Email Address		
Business Address (number, street)	City	State	Zip
Contact Person	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
Full legal name(s) required as well as any assumed Business names(s), address(es), and National Provider Identifier(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."			

1.1 ELECTRONIC DATA INTERCHANGE (EDI) DATA TYPES

This Agreement applies to the following EDI Data Types, when available: (Refer to Provider Service Office Electronic Data Interchange Option Selection Form)

ANSI X 12 837 (Claims/TARs/RTDs/NOAs/Adjustments)
ANSI X 12 276/277 (Claim Status Inquiry/Responses)
ANSI X 12 835 (Claim Payment/Remittance Advice)

1.2 BACKGROUND INFORMATION

The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal Dental electronic Biller.

2.0 DEFINITIONS

The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term "electronic" or "electronically," when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING

The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Medi-Cal Dental Provider Handbook. The Provider hereby acknowledges that he or she has read, and understands the Provider Handbook and its contents, and agrees to read and comply with all Provider Handbook updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION

The Provider agrees by claims submission and certifies under penalty of perjury that all services for which claims are submitted electronically have been personally provided to the member by the Provider or under his or her direction by another person eligible under the Medi-Cal program to provide such services, and such person(s) are designated on the claim. The Provider also certifies by claims submission that the services were, to the best of the Provider's knowledge, medically indicated and necessary to the health of the member. The Provider also certifies that all information submitted electronically is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider/Biller agrees to keep for a minimum period of three years from the date of service an electronic archive of all records necessary to fully disclose the extent of services furnished to the member. A printed representation of those records shall be produced upon request of the Department during that period of time. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California to the California Department of Health Care Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. The Provider also agrees that dental care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability. The Provider/Biller agrees that when applicable using his or her Medi-Cal Dental Remote ID plus DHCS-issued password when submitting an electronic claim will identify the submitter and shall serve as acceptance of the terms and conditions of the Department's Telecommunications Provider and Biller Application/Agreement (ENBPROV). The Provider/Biller further acknowledges the necessity of maintaining the privacy of the DHCS-issued password and agrees to bear full responsibility for use or misuse of the Medi-Cal Dental Remote ID and password should privacy not be maintained.

3.2 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Regardless of whether Provider employs a Biller, the Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all claim information for payment. This includes usual and customary charges for services rendered. The Provider shall also assume personal responsibility for verification of submitted claims with source documents. The Provider/Biller agrees that no claim shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate suspension of electronic billing and program privileges.

3.3 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its fiscal intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015 and, as from time to time amended. The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information relating to that claim may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds and decertification of the Provider/Biller from participation in the Medi-Cal program and/or electronic billing.

4.0 CHANGES IN ELECTRONIC BILLING STATUS

The Provider/Biller and the Department agree that any changes in Provider/Biller status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5.0 PROVIDER/BILLER REVIEWS

The Provider/Biller agrees that agents of the California Department of Health Care Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider/Biller agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of claims submitted electronically.

5.1 NONEXCLUSIVE REVIEWS

The Provider/Biller agrees that the review set out in paragraph 5.0 above is not exclusive but supplements any other form of audit or review the Provider/Biller may be subject to due to its status as a certified Provider/Biller of services under the Medi-Cal or Medicare programs.

6.0 EFFECTIVE DATE

This agreement shall become effective upon approval of the Department.

6.1 TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Department may, however, terminate the agreement immediately pursuant to paragraph 6.2 upon determination that the Provider/Biller has failed or refused to produce or retain source documents in accordance with federal or state law or this agreement.

6.2 TERMINATION FOR CAUSE

If the Provider/Biller is unable to produce source documents on request pursuant to paragraph 5.0, the Department may terminate this agreement immediately by directing its fiscal intermediary to cease payment of any and all electronic claims submitted by Provider/Biller, including any claims in process on the date of such termination. The Provider/Biller has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Biller may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, California Code of Regulations, Section 51015 as from time to time amended. The Department may demand repayment of claims for which no source documents are produced, and the Provider/Biller shall have a right to appeal of such an overpayment finding to the extent provided by Section 14171 of the Welfare and Institutions Code and regulations promulgated pursuant thereto, and as from time to time amended.

6.3 EFFECT OF TERMINATION AND APPEAL

On termination pursuant to paragraph 6.1 or 6.2, the Provider/Biller may submit hard copy claims.

7.0 AGREEMENT BETWEEN PROVIDER AND BILLER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with Billers to submit Medi-Cal Dental electronic billings shall be in conformance with federal and state law governing electronic claims submission, and shall contain provisions including, but not limited to, the following:

a. The Provider shall specifically designate the Biller as the agent to the Provider for the purpose of preparation and submission of Medi-Cal Dental claims by Biller. As the Provider's agent, the Biller agrees to comply with all Medi-Cal requirements on record-making and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Sections 14124.2 and 14124 and Title 22, California Code of Regulations, Section 51476. Provider and Biller shall also execute and comply with the provisions of a Business Associate Agreement entered into under the provisions of the HIPAA Privacy Rule, at 45 CFR 164.504(e).

b. Electronic billing for services rendered to Medi-Cal Dental members shall be prepared by the Biller solely from information supplied by the Provider. This information includes usual and customary charges for services rendered. A printed representation of source documents as defined in Title 22, California Code of Regulations, Section 51502.1 shall be kept, including all information transmitted as a claim by the Provider to the Biller electronically, for a period of at least three years from the date of claims submission.

c. If a department audit is initiated, the Billing Service shall retain all original records described in paragraphs 3.2, 5.0 and 7.0(b) above until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond three years from the date of the service or termination of financial relationship or longer period required by federal or state law.

d. The parties agree that the Department may accept electronic billings prepared, certified, and submitted by the Biller on behalf of the Provider only as long as the agreement between the Provider and the Biller remains in existence and in effect, including the Business Associate Agreement described in paragraph 7.0(a) above.

e. Both parties have a duty to notify the Department in writing immediately upon any change in or termination of their agreements.

8.0 DECLARATION OF INTENT

This agreement is not intended as a limitation on the duties of the parties under the Medi-Cal Act, but rather as a means of clarifying those duties as they relate to the Provider/Biller in its capacity as an authorized Provider/Biller for electronic billing.

8.1 PROVIDER TO HOLD STATE OF CALIFORNIA HARMLESS

Provider agrees to hold the State of California harmless for any and all failures to perform by billing services, billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The Provider explicitly agrees that the Provider is assuming any and all risks that accompany electronic billing and that the Provider is not relying upon the evaluation, if any, that the State has made of the electronic billing system, software, or Biller the Provider is using. Furthermore, the Provider acknowledges that if the electronic billing system, software, or Biller contracted with, is or has been listed as available in Medi-Cal Dental bulletins, that such listing was not an endorsement by the State of California, nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

9.0 CONFIDENTIALITY OF RECORD

The Provider/Biller agrees to maintain adequate administrative, technical, and physical safeguards to protect the confidentiality and security of protected health information in accordance with State and Federal statutes and/or regulations, including 45 Code of Federal Regulations Parts 160 and 164. Any breach of security or unlawful disclosure of protected health information shall be reported to the Department within 24 hours of the Provider/Biller's discovery of such breach or disclosure and may be grounds for termination of this Agreement.

10.0 PROVIDER/BILLER OBLIGATIONS

The Provider/Biller will:

a) Complete and submit to the Medi-Cal Fiscal Intermediary a Medi-Cal Dental Telecommunications Provider and Billing Application/Agreement form for any billers or receivers of any transaction data. The Provider/Biller can be the provider and an outside party (such as a billing service, clearinghouse, or another provider). All billers which are outside parties that have been authorized by a Provider to receive any transaction data must have a Business Associate Agreement in effect between the biller and the Provider, which complies with 45 Code of Federal Regulations, Section 164.504(e).

(b) Not provide the data supplied under this Agreement to any third party except the applicable agents whom the Provider has authorized to provide billing collection and/or reconciliation services and which have a Business Associate Agreement in effect with the Provider, in compliance with 45 Code of Federal Regulations, Section 164.504(e). The Provider acknowledges that any transaction data is confidential information owned by the State, the Medi-Cal Fiscal Intermediary, and/or applicable providers. This provision shall survive the expiration of this Agreement.

(c) Upon review of any transaction data, if the Provider/Biller finds the data unreadable or incorrect, they are instructed to contact the Medi-Cal Fiscal Intermediary for resolution. Failure to report any such data inaccuracies shall constitute acceptance thereof.

(d) The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its Fiscal Intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015, as, from time to time, amended.

PROVIDER SIGNATURE INFORMATION	
Full printed name	Title
Provider signature (original signature required; *DO NOT* use black ink)	Date
BILLING SERVICE SIGNATURE INFORMATION (complete only If "Billing Information" is completed on page 1 of 4)	
Full printed name	Title
Owner or Corporate Office signature (original signature required; *DO NOT* use black ink)	Date

Return Application/Agreement to:

Medi-Cal Dental Program
Correspondence
P.O. Box 15609
Sacramento, CA 95852-0609

DHCS | Medi-Cal Dental

CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507 Web www.Dental.DHCS.ca.gov

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

PROVIDER INFORMATION

1. Provider Name:	2. Doing Business As Name (DBA):		
3. Provider Address – Street:	4. City:	5. State/Province:	6. ZIP Code/Postal Code:

PROVIDER IDENTIFIERS INFORMATION

7. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):	8. National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

9. Provider Contact Name:	10. Telephone Number:	11. Email Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data (Account Number Linkage to Provider Identifier)

12. National Provider Identifier (NPI

13. Method of Retrieval: The only method of retrieval from Medi-Cal Dental is Secure FTP.

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

14. Clearinghouse Name:

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

15. Vendor Name:

16. **Reason for Submission:** ❍ New Enrollment ❍ Change Enrollment ❍ Cancel Enrollment

17. _____ **Authorized Signature**

_____ **Submission Date**

Printed name of provider

Mail the completed form to: Medi-Cal Dental Attention: Correspondence, P.O. Box 15609, Sacramento, CA 95852-0609. To check status, call (916) 853-7373 and ask for EDI Support.

To research and resolve a late or missing v5010 X12 835, please contact Medi-Cal Dental EDI Support at (916) 853-7373 (e-mail: Medi-CalDentalEDI@delta.org). Late or missing is defined as a maximum elapsed time of four business days following the receipt of an associated Electronic Funds Transfer (EFT).

Instructions for Completing the Electronic Remittance Advice (ERA) Enrollment Form

By submitting this form, the provider is authorizing Medi-Cal Dental to provide remittance data electronically.

The ERA is the v5010 X12 835 transaction. For assistance in completing the Electronic Remittance Advice (ERA) Enrollment form, please contact Medi-Cal Dental EDI Support at (916) 853-7373 (e-mail: Medi-CalDentalEDI@delta.org). These instructions may also be found in the EDI section on the Medi-Cal Dental website at www.Dental.DHCS.ca.gov.

PROVIDER INFORMATION

1. Enter the provider name
2. If using a doing business as name (DBA) enter the DBA
3. Enter the provider service office street address
4. Enter the service office city
5. Enter the service office state
6. Enter the service office zip code

PROVIDER IDENTIFIERS INFORMATION

7. Depending on how earnings are reported enter the provider tax identification number (TIN) or Employer Identification number (EIN) or Social Security Number (SSN)
8. Enter the provider National Provider Identifier (NPI) for the service office location

PROVIDER CONTACT INFORMATION

9. Enter the contact name
10. Enter the telephone number for the service office
11. Enter the provider email address

ELECTRONIC REMITTANCE ADVICE INFORMATION

12. Enter the provider National Provider Identifier (NPI) for the service office location; must match the preference for ERA payment.
13. Method of retrieval: The only method of retrieval from Medi-Cal Dental is Secure FTP.

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

14. If applicable, enter the name of the provider's Electronic Data Interchange (EDI) clearinghouse

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

15. If applicable, enter the name of the provider's Practice Management System/Software vendor

REASON FOR SUBMISSION

16. Check the ERA action "New Enrollment", "Change Enrollment" or Cancel Enrollment"

OTHER

17. Sign and date the ERA form; requires the provider's original signature

Mail the completed form to: Medi-Cal Dental
Attention: Correspondence
P.O. Box 15609
Sacramento, CA 95852-0609.

To check status, call (916) 853-7373 and ask for EDI Support.

To research and resolve a late or missing v5010 X12 835, please contact Medi-Cal Dental EDI Support at (916) 853- 7373 (e-mail: Medi-CalDentalEDI@delta.org). Late or missing is defined as a maximum elapsed time of four business days following the receipt of an associated Electronic Funds Transfer (EFT).

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MEDI-CAL DENTAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507 Web www.Dental.DHCS.ca.gov

PROVIDER SERVICE OFFICE ELECTRONIC DATA INTERCHANGE OPTION SELECTION FORM

1. Reason for Submission: ❍ New Enrollment ❍ Change Enrollment ❍ Cancel Enrollment

2.Provider Name:	3.National Provider Identifier (NPI):		
4.Business Name:			
5.Provider Address – Street:	City:	State:	ZIP Code:
6.Provider Contact Name:	Telephone Number:		
7.Software/Practice Management System:	8.Email Address:		

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
For assistance, contact EDI Support at (916) 853-7373 or by email to Medi-CalDentalEDI@delta.org.

INPUT FROM:

9a. ❍ Service Office
9b. ❍ Billing Office
9c. ❍ Clearinghouse Name: _____
You will submit Claims, TARs and Adjustments (ANSI X 12 837).

Will you also submit:

10. NOAs electronically?	❍ **YES**	❍ **NO**
11. Claim Status Inquiry (ANSI X 12 276)?	❍ **YES**	❍ **NO**

RETURN OUTPUT OPTIONS: *Standard options are shaded*:

12. Electronic RTDs	❍ **YES**	❍ **NO**
13. Electronic NOAs	❍ **YES**	❍ **NO**
14. Electronic EOB Supplemental Claim Data (If YES: ❍ SUMMARY or ❍ DETAIL)	❍ **YES**	❍ **NO**
15. Would you like to stop receiving Explanations of Benefits (EOBs) by mail?*	❍ **YES***	❍ **NO**

**If YES, EDI Support will contact your office to determine the effective date.*
***NOTE:** Opting not to receive paper EOBs by mail is an option **only** if either the 835 ERA and/or Supplemental EOB file in the Detail format are received.*

Mandatory options are pre-selected:

16. Electronic X-Ray/Attachment Labels (CP-O-971-P2 & CP-O-971-P)	● **YES**	(❍ 1-UP or ❍ 3-UP)
17. Report of Documents Awaiting Return Information (CP-0-978-P)	● **YES**	
18. Report of EDI Documents Received (CP-0-973-P)	● **YES**	
19. Claim Status Inquiry Response (ANSI X 12 277)	❍ **YES**	❍ **NO**

20. Print the name of the provider
(last) (first) (middle)

21. Signature of provider

_____ _____
Signature Date

Return completed form to: Medi-Cal Dental Program
Correspondence
P.O. Box 15609
Sacramento, CA 95852-0609

INSTRUCTIONS FOR COMPLETION OF THE PROVIDER SERVICE OFFICE ELECTRONIC DATA INTERCHANGE OPTION SELECTION FORM

Type or print clearly in ink. Return completed form to:

Medi-Cal Dental Program
Correspondence
P.O. Box 15609
Sacramento, CA 95852-0609

1. Reason for Submission: Check the enrollment action requested:
   - New Enrollment – check if applicant is not currently enrolled to submit electronically to Medi-Cal Dental.
   - Change Enrollment – check if applicant is requesting to modify existing EDI enrollment options.
   - Cancel Enrollment – check if applicant is requesting to deactivate EDI enrollment.

2. Provider Name: Enter the provider's legal name.

3. National Provider Identifier (NPI): Enter the Billing provider's National Provider Identifier (NPI) for the business address indicated in item 5.

4. Business Name: Business name if different than the provider's legal name listed in item 2.

5. Provider Address: Enter the actual business location including the street name and number, room or suite number or letter, City, State, and ZIP Code. A post office or commercial box is not acceptable.

6. Provider Contact Name: Enter the name and telephone number of the individual who can be contacted by EDI Support staff to answer questions regarding the application.

7. Software/Practice Management System: Enter the name of the provider's software vendor or practice management system used for billing.

8. Email Address: Enter the provider's email address.

EDI INPUT/OUTPUT OPTIONS:

INPUT FROM: Refers to the source and type of EDI data **the provider will submit** electronically to Medi-Cal Dental.

9a. Service Office: Check if applicant will submit directly to Medi-Cal Dental for the business location noted in item 5. Note: certification testing is required.

9b. Billing Office: Check if the applicant will submit directly to Medi-Cal Dental from a central location for more than one business location. Note: certification testing is required and each location must be enrolled to submit electronically.

9c. Clearinghouse Name: Check if the applicant will submit through a certified clearinghouse. Next to Name, enter the name of the clearinghouse.

10. Will you also submit NOAs electronically?: Check YES if the applicant will respond to EDI Notices of Authorization (NOAs) electronically to submit them for payment or request reevaluation. Check NO if the applicant will respond to EDI NOAs only by mail.

11. Will you also submit Claim Status Inquiry (ANSI X 12 276)? Check YES if the applicant will submit the 276 Health Care Claim Status Request transaction. Check NO if the applicant will not submit the 276 transaction.

RETURN OUTPUT OPTIONS: Refers to EDI reports and data **the provider will receive** electronically Medi-Cal Dental through the same source selected in item 9a-c. Some options are standard or are determined by the provider's software and/or clearinghouse noted in item 7 and 9c. Providers are required to receive EDI reports noted in item 16, 17 and 18. Refer to the Medi-Cal Dental EDI How-To Guide for samples and descriptions of these reports.

12. Electronic RTDs*: Check YES if the applicant wants to receive Resubmission Turnaround Documents (RTDs) for electronically submitted documents. Check NO if the applicant wants to receive RTDs by mail.

13. Electronic NOAs*: Check YES if the applicant wants to receive Notices of Authorizations (NOAs) for electronically submitted Treatment Authorization Requests (TARs). Check NO if the applicant wants to receive NOAs by mail.

14. Electronic EOB Supplemental Claim Data*: Check Yes if the applicant wants to receive electronic Explanation of Benefits (EOBs). Please check with your clearinghouse to see if this is an option they offer and if so whether they support receipt in a Summary or Detail format. Check No if the applicant does not wish to receive Supplemental EOBs.

*EDI RTDs, NOA, Supplemental EOBs and ERAs are considered standard options by various clearinghouses. Providers should check with their clearinghouse, if applicable, to verify whether availability is supported. See separate Electronic Remittance Advice (ERA) Enrollment Form to receive the X12 835 transaction.

15. Would you like to stop receiving Explanation of Benefits (EOBs) by mail?: Check YES if the applicant wants to discontinue receiving EOBs by mail. This is only an option if the provider is receiving either the 835 ERA and/or Supplemental EOB data in the Detail format. Check NO if the applicant wants to continue receiving EOBs by mail.

16. Electronic X-Ray/Attachment Labels: Electronic X-Ray/Attachment Labels: This is a mandatory option to enable the applicant to receive Medi-Cal Dental EDI report CP-O-971-P2 (Office X-Ray/Attachment Request Label) and associated Medi-Cal Dental EDI report CP-O-971-P (X-Ray/Attachment Request Report). Labels can be provided 1-up (four labels per page in a single column) or 3-up (12 labels per page in three columns).

17. Report of Documents Waiting Return Information: This is a mandatory option to enable the applicant to receive Medi-Cal Dental EDI report CP-O-978-P (Provider/Service Office Daily EDI Documents Waiting Return Information > (greater than) 7 Days).

18. Report of EDI Documents Received: This is a mandatory option to enable the application to receive Medi-Cal Dental EDI report CP-O-973-P (Provider/Service Office Daily EDI Documents Received Today).

19. Claim Status Inquiry Response: Check YES if the applicant wants to receive the 277 Health Care Claim Status Inquiry transaction in response to the 276 Health Care Claim Status Request transaction (mark YES if item 11 was also marked YES). Check NO if the applicant does not want to receive the 277 transaction or if item 11 was marked NO.

20. Print name of provider: Print the last, first and middle name of the person who is signing the application. The application must be signed by a person who is authorized to legally bind the provider or applicant.

21. Signature of provider: An original signature of the individual named in item 20 is required. Include the Signature Date.