DHCS | Medi-Cal Dental

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
Provider Enrollment
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
Provider Enrollment
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.