CPSP PROVIDER
DUAL PROVIDER AGREEMENT

	INITIALS	
	Provider #1	Provider #2
1. The CPSP provider that bills the initial combined assessment (Z6500) or any of the initial assessment procedures (Z6300, Z6402, Z6200) will be the Case Coordinator for all services using the Individualized Care Plan (ICP). This provider will inform the patient that they are her case coordinator for all CPSP services. (Refer to California Code of Regulations (CCR) section 51179.7 – “Case Coordination”)	_________	_________
2. Each provider will maintain a description of how medical records will be shared and billing coordinated between providers during the antenatal, intrapartum, and postpartum periods of care.	_________	_________
3. Each provider will bill only for the services that the provider Directly renders. There will be no duplicate billing of services, and service limits as specified in regulations **for an individual patient** will not be exceeded. (Refer to CCR section 51504, “Comprehensive Perinatal Services”)	_________	_________
4. If more than one provider provides OB services, each provider will bill on a fee-for-service basis for all services provided (e.g., neither provider will bill globally.)	_________	_________
5. If only one CPSP provider provides the OB portion of care, global billing is allowable.	_________	_________
6. Each patient will be provided written instructions telling her how to obtain emergency care throughout the pregnancy.	_________	_________
7. When billing for a CPSP service which has a prerequisite requirement that has been performed and billed by another provider, the biller must indicate in the “Remarks” portion of the Medi-Cal claim form that the prerequisite service was performed by another identified provider. (e.g., identified by name and Medi-Cal Provider number.)	_________	_________
8. Care will be provided under only one “Individualized Care Plan” for each patient.	_________	_________

Provider #1

____
Provider Name

____
Address

____
City, State, Zip Code

____
NPI – Medi-Cal Provider #

____
Authorized Agent, Signature

____
Title of Authorizing Agent

____
Date Agreement

Provider #2

____
Provider Name

____
Address

____
City, State, Zip Code

____
NPI – Medi-Cal Provider #

____
Authorized Agent, Signature

____
Title of Authorizing Agent

____
Date Agreement