

Appendix C



**Emergency Medical Services Appropriation (EMSA)  
Contract Back Program  
ELECTRONIC BILLING CERTIFICATION FORM**

**Mail Claims to:**  
 Department of Public Health  
 Office of County Health Services  
 EMSA Contract Back Program  
 Attn: Marlene Carrillo  
 1616 Capitol Avenue, Suite 74-317  
 P.O. Box 997377, MS 5203  
 Sacramento, CA 95899-7377

1. Sole Provider/Group Medi-Cal Number: \_\_\_\_\_
2. Sole Provider/Group Name: \_\_\_\_\_
3. Provider's Name: \_\_\_\_\_ 4. Provider's EMSA Enrollment #: \_\_\_\_\_
5. Total Number of Claims Being Submitted for This Provider: \_\_\_\_\_
6. Total Claims Billing Amount Being Submitted for This Provider: \_\_\_\_\_
7. HCFA/CMS 1500 Forms Attached Alphabetically

This Electronic Billing Certification Form is to be completed for a sole individual physician and/or a group physician who is having MORE than 25 claims being submitted on their behalf. The form(s) must be accompanied by a 3.5" floppy disk or CD containing each patient's claims information and must be accompanied by corresponding HCFA/CMS 1500 forms. The 3.5" floppy disk or CD must be correctly formatted according to the EMSA Policy and Procedures Manual "Data File Format"; and MUST be encrypted and password protected. **NOTE: ALL disk and CD submissions MUST be labeled, encrypted and password protected.** EMSA's universal password will be the date created using the word "created with a 2 digit month, day, year (i.e. created010101).

**An Annual Physician Enrollment and Certification Form for the fiscal year which corresponds to the dates of service for claims being submitted must be on file with the EMSA Contract Back Program.**

Note: Pursuant to Welfare & Institutions Code, Section 16953 an "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which in the absence of immediate medical attention could result in any of the following: placing the patient's health in serious jeopardy; serious impairment to bodily functions; and/or serious dysfunction to any bodily organ or part.

**8. Affidavit of Provider or Provider's Representative**

This is to certify that the information contained in this electronic billing submission is true, accurate and complete. By submitting and signing this claim form, I, as the attending physician or authorized certified representative, hereby certify that on the third billing attempt, a copy of the HIPAA "Notice of Privacy Practices" for the EMSA Contract Back Program (Program) was provided to the patients named in this submission, as required by the Program. I also certify that the physician/physician group has read, understands and agrees to be bound by and comply with the policies, conditions and statements contained in the Program's Policies and Procedures Manual, related statutes and regulations and the Program's Annual Enrollment and Certification Form. I further certify and agree to cease all current and future collection efforts when any level of reimbursement of this claim is received from the Program.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Authorized Representative