

Appendix A

Emergency Medical Services Appropriation (EMSA)
Contract Back Program



ANNUAL PROVIDER ENROLLMENT AND CERTIFICATION FORM

Fiscal Year (FY) 200__ - 200__

Mail Claims to:

California 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

Eligible medical providers who anticipate submitting medical claims for reimbursement from the EMSA program MUST complete and submit this form by July 1st.

Section 1: Attending Medical Provider's Information

1. Type of Enrollment
 Check a Box → **NEW Provider Enrollment** **Recertification Enrollment**

2. Provider's Last Name [Grid] 3. Provider's First Name [Grid] 4. Zip Code [Grid]

5. Mailing Address [Grid] 6. City [Grid]

7. SSN or Federal Tax Number [Grid] 8. Attending Provider's Medi-Cal Number [Grid] 9. Attending Provider's California Medical License [Grid] 10. State [Grid]

11. Attending Provider's Office Phone Number ([Grid]) [Grid] - [Grid] [Grid] 12. Contact Person [Grid]

Section 2: Physician's Medical Group Information (if applicable)

13. Medical Group Name [Grid] 14. Zip Code [Grid]

15. Mailing Address [Grid] 16. City [Grid]

17. Federal Tax Number [Grid] 18. Group's Medi-Cal Number [Grid] 19. State [Grid]

20. Medical Group's Office Phone Number ([Grid]) [Grid] - [Grid] [Grid] 21. Contact Person [Grid]

Section 3: Physician/Group Billing Agency Information (if applicable)

22. Name of Billing Agency [Grid] 23. Zip Code [Grid] 24. State [Grid]

25. Billing Agency's Mailing Address [Grid] 26. City [Grid]

27. Billing Agent's Office Phone Number ([Grid]) [Grid] - [Grid] [Grid] 28. Billing Representative Name [Grid]

29. E-Mail Address [Grid]

Section 4: Warrant and Tax Information and Authorization

Issue warrants in the name of:
(Choose from Section 1 or 2)

30. Issue Warrants in the name of the:
 Attending **Physician**
 Provider's Medical Group

Mail Warrants to the address of the:
(Choose from Section 1, 2, or 3)

31. Mail Warrants to the address of the:
 Attending **Physician**
 Provider's Medical Group
 Billing Service

32. I authorize all warrants to be issued and mailed as indicated above, using the associated tax identification number I have provided.

Date Enrolled	Official EMSA Use Only
Analyst Initials	EMSA Enrollment Number

Date

Attending Provider's Signature
 (BLUE INK, no stamps or representatives)



EMSA ANNUAL PROVIDER ENROLLMENT AND CERTIFICATION

Section 5: Facility Information

In the following table identify all facility locations where emergency services will be rendered and for which claims will be billed to the EMSA program. Billings for facilities not identified on this list will be returned unprocessed. For additional facilities, please use a second enrollment form.

Service Location Information				
	Facility Name	Facility's Address	County Number	Facility Number (EMSA USE ONLY)
33.	a.	b.	c.	
34.	a.	b.	c.	
35.	a.	b.	c.	
36.	a.	b.	c.	

Section 6: Attending Provider Certification

I, certify that:

37. Initial all claims submitted during this certification's fiscal year will meet all the conditions and requirements of being deemed an "Emergency", in accordance with the EMSA Policies and Procedures Manual and the following statutory conditions:

Pursuant to Welfare and Institution Code, Section 16953 "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;

38. Initial the attending provider/physicians group/billing service has and will maintain documentation indicating that a third party payor source inquiry has been made AND that the patient or the responsible financial party has been billed for payment of services on three occasions;

39. Initial the claim(s) will not have been paid in WHOLE or PART by: the patient, any private insurance carrier, any program funded in whole or in part by the federal government, or ANY other payer source. (i.e., Medi-Cal, Medicare, California Children's Services, etc.);

40. Initial the attending provider/physician's group/billing service has and will maintain documentation indicating that: 1) a period of not less than three months has passed from the date the patient or responsible third party was last billed, during which time reasonable efforts were made to obtain reimbursement and that no reimbursement for ANY portion of the amount has been received; or 2) actual notification from the patient or responsible third-party has been received indicating that no payment will be made for the services rendered by the physician.

(Source: Welfare & Institutions Code, Sections 16952(f) and 16955(a)(b)(c))

"Notice of Privacy Practices" Agreement

41. Initial By enrolling into the EMSA Contract Back Program, I, as the attending medical provider, acknowledge and understand my responsibility to provide patients with a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Program in order to submit claims to the EMSA Program. This is in addition to any "Notice of Privacy Practices" which I give my patients as a medical provider. If a patient has not met their financial obligation for medical services received, I will or will instruct my billing agent to, at the time of the third billing attempt, provide the patient, parent and/or responsible guardian with a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Program.

42. Initial I also understand that my responsibilities and obligations include, but are not limited to, the preparation, maintenance, and retention of service and financial records pertaining to any claims submitted, and the availability of those records for review and audit. I also understand that I am responsible for refunding all claim overpayments and providing restitution for any audit exceptions identified during an EMSA Contract Back Program case review.

43. _____
Date

Attending Provider's Signature
(BLUE INK, no stamps or representatives)

Section 7: Appointing/Authorizing A Billing Representative

44. I, as the attending medical provider authorize _____ of _____
(Name of Authorized Billing Representative) (Name of Physician's Office or Billing Agency)
 to act on my behalf for the submission of claims and all documents required for reimbursement of eligible uncompensated medical services from the EMSA Program.

Date

Attending Provider's Signature
(BLUE INK, no stamps or representatives)