
CMC Enrollment Procedures

Page updated: February 2022

This section describes the Computer Media Claims (CMC) enrollment requirements and procedures for providers and billing services interested in submitting claims through computer media.

Provider Participation Requirements

Participation as a CMC submitter is open to all Medi-Cal providers including Child Health and Disability Prevention (CHDP) program providers, assuming submitted claims are on an acceptable medium, in the proper format, and claims data meets the criteria for CMC billing.

The following two requirements are mandatory for CMC submission:

- The California MMIS Fiscal Intermediary must verify ability to produce claims data on acceptable media and in the proper format.
- The Department of Health Care Services (DHCS) must authorize participation in the CMC billing program.

CHDP CMC Requirements

All CHDP program/Medi-Cal fee-for-service claims, including those submitted for recipients who require a CHDP Eligibility Information form (DHCS 4073), are acceptable by means of Computer Media Claims (CMC).

Application/Agreement Forms

«DHCS and the CA-MMIS FI require a signed telecommunication application/agreement form from CMC submitters.» Providers and billing services must submit the form prior to testing and implementation of CMC billing.

The *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153) is available on Medi-Cal Provider website “Forms” page.

Billing Services

«Providers may employ a billing service to prepare and submit their CMC. Contracts between individual providers and independent billing services are required, and copies should be retained by both parties.»

Audits

DHCS may conduct periodic audits of provider or billing service records to ensure compliance with Medi-Cal electronic billing requirements. Providers and billing services should maintain all documentation required by the application/agreement form.

Electronic Formats

CMC offers several electronic billing formats. Submitters are to select the format that corresponds to their claims type as described below:

Table of Electronic Format Claim Types

Electronic Format	Claim Type
ANSI ASC XI2N 837 – v.5010 Professional (005010X222A1)	05, 07
ANSI ASC XI2N 837 – v.5010 Institutional (005010X223A2)	02, 03, 04

Submitting Claims on Multiple Media

To submit claims on multiple media, providers must submit an individual application/agreement form for each media format.

Submitting Claims from Physician Groups

Application/agreement forms from physicians and physician groups must contain the group provider number and the signature of an authorized physician within the group. Individual providers who bill with the group number do not need to submit separate provider application/agreement forms.

Medi-Cal Application/Agreement Form Requirements

Providers must submit Medi-Cal application/agreement forms according to the following instructions.

Provider Submission

Providers submitting electronic claims through a billing service must complete and sign the provider portion of the telecommunications application/agreement form. <<This form must be completed along with the biller information before the service can submit CMC on the provider's behalf.>>

Billing Service Submission

Billing services submitting electronic claims must complete the biller portion of the telecommunications application/agreement form. Each provider for whom the billing service submits claims must complete the provider portion of this form.

Completion Instructions for Application/Agreement Forms

«Providers must follow the instructions below when completing the application/agreement form. All provisions of the agreement must be carefully read prior to signing. All forms that contain incorrect provider information will be returned.»

Provider Information

Identification of Parties

Provider Name: Enter the legal name of the provider as listed with DHCS.

DBA: Doing Business As (if different from Medi-Cal provider name).

Provider Number: Enter the provider number.

Provider Service Address/City, State, ZIP Code: Address where provider renders services as listed in the DHCS Provider Master File (PMF). All agreements that contain incorrect provider addresses will be returned.

Note: Providers who have submitted a change of address or have moved within the last three months should call the Telephone Service Center (TSC) at 1-800-541-5555 and select the option for CMC inquiries to verify that their correct Provider Service Address is listed on the PMF.

«**Contact Person:** List the person(s) to be contacted for questions regarding CMC.»

Contact Person Address/City, State, ZIP Code: Address of contact person if other than *Provider Service Address*.

Contact Telephone Number: Current telephone number, including area code, where the contact person may be reached from 8 a.m. to 5 p.m., Monday through Friday.

If Currently an Approved Submitter, Assigned Submitter Number: Enter assigned submitter number, if any, to ensure application is processed accurately.

Note: A change of address does not require a new submitter number. However, if the provider's name or number changes, a new submitter number is required and a new agreement form must be filled out.

Biller Information

Biller Name: «Enter the legal name of the party submitting claims to the CA-MMIS FI (if other than the provider of service).»

DBA: Doing Business As (if other than the provider of service).

Biller Phone Number: Current telephone number, including area code, where the contact person may be reached or a message may be left, from 8 a.m. to 5 p.m., Monday through Friday.

Business Address/City, State, ZIP Code: «Address of billing service or provider office where correspondence will be sent regarding CMC.» This would be the same as *Provider Service Address/City, State* unless billing through a billing service. If the provider is also the submitter, the *Biller Information* section of the application does not need to be completed. However, if the provider's billing address differs from the service address of the provider number on the application (for example, billing is from a corporate office), the *Biller Information* section must be completed.

Contact Person: «List the person(s) to be contacted for questions regarding CMC.»

If Currently an Approved Submitter, Assigned Submitter Number: Enter assigned submitter number, if any, to ensure application is processed accurately.

Note: A change of address does not require a new submitter number. However, a change of name requires a new agreement form to be filled out by each provider enrolled with the submitter.

Submission Type

DHCS 6153

CMC Batch Submission Type: Choose Internet. Choose only the submission types intended for use.

Real Time Submission Type: Choose Point of Service (POS), leased line or Internet. For Internet Professional Claim Submission (IPCS), select Internet in addition to 5010X222A1 on the space next to "ANSI X12 837 Version (indicate version)". «Refer to the [IPCS User Guide](#) for further information.» Choose only the submission types intended for use.

Claim Type: Check the box next to the applicable claim type(s).

- If using ANSI ASC X12 837 Professional Claim Types 05 and 07, indicate Version 5010X222A1.
- For Institutional claim types 02, 03 and 04, indicate Version 5010X223A2.

Refer to "Electronic Formats" on a previous page for more information regarding the claim type and applicable format types.

Note: ANSI ASC X12 278 is for future use.

Provider/Billing Service Signature Information

The provider/billing service signature information should follow the standards listed below.

Full Printed Name: Print name of authorized person signing agreement.

Provider Signature: Signature must be legible and original (no stamps or copies). Do not use black ink. The title of the signer and the date signed must be included. Persons authorized to sign are:

Pharmacy

- Owner
- President/vice president of company
- Pharmacy administrator
- Director
- Chief Executive Officer (CEO)
- Pharmacist/pharmacist-in-charge
- Corporate officer
- Director of third party operation
- Claims coordinator
- Vice president of pharmacy division
- Regional manager for large pharmacy chains

Facilities

- Owner
- Administrator
- Director
- President/vice president of company
- Assistant administrator
- Chief Financial Officer (CFO)
- Chief Executive Officer (CEO)
- Chief Medical Officer (CMO)
- Controller
- Treasurer
- Patient financial services director
- Director of central business office
- Director of county agencies
- County health services administrator

Individual Providers

- Individual enrolled provider

Physician and Allied Group Providers (Including Facility Based Groups)

- Active group member

University of California, San Francisco (UCSF) – Kaiser – Sutter Group

- Chief Medical Officer (CMO)
- Chief Executive Officer (CEO)
- President/vice president
- Division manager of patient business services
- Chief administrator
- Owner (Allied only)
- Vice president of financial operations

Note: Kaiser applications signed by business consultants will not be accepted.

Colleges

- Campus president
- Chief Business Officer (CBO)
- Director of students health program
- Campus vice president
- Chief Executive Officer (CEO)

«Local Educational Agency (LEA)»

- Assistant superintendent
- Business services/fiscal officer
- «Campus president
- Campus vice president
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Director of Student Health»
- Superintendent

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Providers

- Individual provider only

Non-Medical Transportation

- Owner
- President/vice president
- Chief Executive Officer (CEO)

Health Access Programs (HAP)

- Owner
- Administrator
- Director
- President/vice president of company
- Assistant administrator
- Chief Financial Officer (CFO)
- Chief Executive Officer (CEO)
- Chief Medical Officer (CMO)
- Controller
- Treasurer
- Patient financial services director
- Director of central business office
- Director of county agencies
- County health services administrator

Prison Industry Authority (PIA)

- Prison Industry Administrator

Government Fire Agency – Medical Transportation City/Municipal/County/State Fire Department

- Fire chief
- Acting fire chief
- Division chief

Tribal Health Program (THP)

- Tribal chairperson
- Owner
- Administrator
- Director
- President/vice president of company
- Assistant administrator
- Chief Financial Officer (CFO)
- Chief Executive Officer (CEO)
- Chief Medical Officer (CMO)
- Controller
- Treasurer
- Patient financial services director
- Director of central business office
- Director of county agencies
- County health services administrator

Orthotics and Prosthetic (O&P)/Durable Medical Equipment (DME)/Hearing Aid Dispenser/Dispensing Optician Providers

- Owner
- President/vice president
- Chief Executive Officer (CEO)

Laboratories

- Director
- Owner
- President/vice president
- Department administrator

Billing Service Signature: Signature must be legible and original (no stamps or copies). Do not use black ink. The title of the signer and the date must be included.

The CMC application/agreement form must be filled out completely. Each section must have a proper entry or notation of NA (not applicable). All application/agreement forms must contain the original signature of an authorized person responsible for claims submission, as specified above. DHCS will reject all application/agreement forms with an unauthorized signature.

Acceptable Biller Signatures

- Owner
- President/vice president
- Director
- Administrator/assistant administrator
- Partner
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Executive director
- Director of operations
- Director of third party
- Pharmacy claims coordinator
- Divisional or regional manager
- Accounting director
- Business office director

Where to Submit Application/Agreement Forms

«All application/agreement forms must be sent to the CA-MMIS FI:»

Attn: CMC Unit
California MMIS Fiscal Intermediary
P.O. Box 15508
Sacramento, CA 95852-1508

CMC Submitter Number

After receiving the telecommunication application/agreement form, the CMC Unit assigns a unique three-character submitter number. This number identifies all claims submitted by the CMC submitter and is mandatory on all claim submissions, including test submissions. CMC will mail this number to the submitter.

Refer to the *Testing/Activation Procedures* section of the *Medi-Cal Computer Media Claims (CMC) Billing and Technical* manual for information about the CMC testing and activation process.

Reporting Submitter Status Changes

The FI must be informed of any changes in a submitter's status. Proper written notification is required under the following circumstances.

Provider Changes From Billing Service to Direct Submission

Either the provider or the billing service must submit a letter identifying the billing service and provider numbers involved and specifying the termination date. The provider must submit a new telecommunication application/agreement form.

Note: The provider must be approved as a CMC submitter before claims may be submitted through CMC.

Provider Changes From Direct Submission to Billing Service

A letter is required providing the submitter number, name, and the address of the billing service. The billing service must submit a new telecommunication application/agreement form.

Provider Name/Number Changes

A new telecommunication application/agreement form is required for newly assigned provider numbers. The application/agreement form must include the submitter number in the Assigned Submitter Number field.

Include a letter with the previous provider name and number.

Note: The new provider number must receive DHCS authorization before claims can be submitted through CMC.

Provider Adds a New Provider Number

A new telecommunication application/agreement form is required for a new provider number. The application/agreement form must include the submitter number in the *Assigned Submitter Number* field.

Note: The new provider number must receive DHCS authorization before claims can be submitted through CMC.

Billing Service Adds a New Provider Number

The billing service must submit a signed telecommunication application/agreement form when adding a new provider number.

Provider Changes Business Location

Change of business location requires a letter containing the submitter number plus both old and new addresses and telephone numbers. The letter must include an authorized signature.

If the relocation involves a new provider number, a new telecommunication application/agreement form is required. Requests must be sent to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Provider Changes Billing Service

A letter including the submitter number, name and address of new billing service, the name of the previous billing service and the effective date of the change is required. The new billing service must submit a new telecommunication application/agreement form.

Other Deletions of Authorized Provider Numbers

A letter is required stating the provider number(s), provider name, associated submitter number and effective date.

Where to Submit Change in Status Correspondence

All correspondence regarding change in status should be sent to the following address:

Attn: CMC Unit
California MMIS Fiscal Intermediary
P.O. Box 15508
Sacramento, CA 95852-1508

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.