# MEDI-CAL

**Supplemental Claims Payment Information (SCPI) Enrollment**

(PROVIDER)

| **FI USE ONLY** | Start Date: _____/_____/_____ Receiver ID: _____ |
|---|---|

## I. PROVIDER/CONTACT INFORMATION:

**Address listed below is the "Pay-To" address on DHCS Provider Enrollment records?** ☐ **(✓ = Yes)**

**Address as specified on DHCS Provider Enrollment records:**

Contact Person _____

Phone Number _____

Email Address _____

Provider Name _____

Provider Address _____

City _____State _____ Zip_____

## II. TESTING:

○ REQUIRED (FI provides a test file in the format requested)
○ NOT REQUIRED (FI provides production data on the Medi-Cal Transaction Services)

## III. DISTRIBUTION METHOD:

**MEDI-CAL Transaction Services**

Do you have a Windows-compatible system with a current version of a Web browser such as Microsoft Internet Explorer or Mozilla Firefox, or do you have Internet access through an Internet Service Provider (ISP) in order to download SCPI files from Medi-Cal Transaction Services?

○ YES

○ NO (I do not have access to one or more of these resources noted above.)

## IV. FEES:

1. During the term of this agreement, Provider agrees to pay the FI, through a separate invoice, for services as follows:
   a) A recreation fee of $125.00 for each SCPI file that is past the five-week availability on the Medi-Cal Transaction Services.
   b) An administration fee of $15.00 to add, change or delete each provider number. Up to ten provider numbers may be added during enrollment at no charge.
2. The Provider agrees to pay DHCS through the regular Medi-Cal claims payment system as follows:
   a) A fee of $0.02 (2 cents) per Adjudicated Claim Line (ACL) shall be charged to the provider for the provider's hardcopy paper Remittance Advice Details (RAD) when the provider requests for a copy to be delivered to the provider's business address.

## V. PROVIDER RELEASE AUTHORIZATION:

Please fill in the complete 9- or 10-digit provider number along with the last four digits of their Federal Tax ID Number (TIN) for each provider that you are requesting to receive SCPI records for the receiver listed in section I.

***Note:*** *If "'YES" is not marked, "No" will be the default value for receiving Paper RAD and Medicare "No-Pay" crossover data records.*

| **Provider number and Last four digits of TIN** | **Provider Name** | **Receive Paper RAD?** | **Receive Medicare "No-Pay" Records?** |
|---|---|---|---|
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |
| _____ | _____ | ○ NO ○ YES | ○ NO ○ YES |

I certify by signing this release that I am authorized to sign on behalf of the provider specified and to the best of my knowledge and belief the information furnished is correct. I also certify by signing this release that I permit the Department of Health Care Services (DHCS) to collect from the provider's regular Medi-Cal claims payment, $0.02 (two-cents) for every Adjudicated Claim Line (ACL) processed when the provider requests for a hardcopy paper RAD. Furthermore, I agree to notify the FI, in writing, should any change to the information provided above occur. Other charges shall be assessed as set forth in section IV (Fees).

Authorized Signature: _____

Print Name: _____

Title: _____

Date: _____

**Return Agreement To**:

Xerox State Healthcare, LLC
Attn: SCPI Operations
820 Stillwater Road
Sacramento, CA 95605