Provider Manual

Department of Health Services
Children's Medical Services Branch

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SECTION 1.0 - GENERAL INFORMATION

Introduction - How To Use This Manual

The *Newborn Hearing Screening Program (NHSP) Provider Manual* has been prepared by the State Department of Health Services, Children's Medical Services (CMS) Branch. This manual addresses the specific program policies, billing codes and procedures for completing claims for NHSP services and diagnostic hearing evaluation services rendered to newborns and infants by eligible providers.

The manual is intended to be used in conjunction with the *California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) Provider Manual*, the *Medi-Cal Provider Manuals* and the monthly *Medi-Cal Update* bulletins. Also, the manual is designed to allow the replacement of pages as program information changes. Such changes will be mailed automatically to you.

SECTION 1.1 - NEWBORN HEARING SCREENING PROGRAM

Background

The California Newborn Hearing Screening Program (NHSP) was established as a result of Assembly Bill 2780, Chapter 310, Statutes of 1998. This law requires the establishment of a comprehensive hearing screening program for the early detection of hearing loss in newborns and infants, with access to diagnostic evaluations and follow-up services, and provisions for data collection and reporting. The Department of Health Services (Department), specifically the Children's Medical Services (CMS) Branch, has responsibility for the implementation and oversight of this program.

Prior to the NHSP, only infants receiving care in a CCS-approved neonatal intensive care unit (NICU) who were at “high risk” for deafness were screened for hearing loss. Follow-up services for the infants identified with a hearing loss were provided through the CCS High-Risk Infant Follow-up Program.

Now, all CCS-approved hospitals with licensed perinatal services and all CCS-approved NICUs are required to develop and administer their own hearing screening program for newborns and infants born in the hospital or receiving care in the NICU. California has over 500,000 births per year. With approximately 400,000 of these births occurring in CCS-approved hospitals, more infants than ever before will receive a hearing screen. It is anticipated that the NHSP will result in the identification of an estimated 1,200 newborns and infants born each year with a significant hearing loss who will be linked with appropriate follow-up and early intervention services.

Program Overview

The NHSP is a comprehensive and coordinated system of early identification, tracking and monitoring of hearing screening, access to diagnostic services, and coordination of appropriate intervention and support services for newborns and infants with hearing loss. The goal of the program is to identify newborns and infants with a hearing loss prior to three months of age and to implement audiological and early intervention services by six months of age.

Under the NHSP, all CCS-approved hospitals with licensed perinatal services are required to perform inpatient hearing screening on all newborns, with the parent's permission, prior to hospital discharge. All infants receiving care in a CCS-approved NICU must receive inpatient infant hearing screening services prior to discharge. Inpatient infant hearing screening includes a repeat hearing screen prior to discharge if the newborn or infant did not pass the initial inpatient hearing screening.

Newborns and infants who do not pass the inpatient infant hearing screening are referred to an outpatient infant hearing screening provider for hearing rescreening that should be performed within one month of discharge. Newborns and infants who were born in a CCS-approved hospital but were discharged from the birthing hospital before inpatient infant hearing screening services were offered or provided will be referred to an outpatient infant hearing screening provider. Providers who can be certified as outpatient infant hearing screening providers include: NHSP-certified inpatient infant hearing screening providers; CCS-approved Type A, B, and C Communication Disorder Centers (or Level 1, 2, or 3 Hearing and Speech Centers); and CCS-paneled audiologists, pediatricians, otolaryngologists, and family practice physicians.

Newborns and infants who do not pass the outpatient initial hearing screening or the outpatient hearing rescreening are referred to a CCS-approved Type C Communication Disorder Center (or Level 3 Hearing and Speech Center) for a diagnostic hearing evaluation and to the local CCS program for authorization of this evaluation.

Newborns and infants receiving care in a CCS-approved NICU who do not pass the inpatient hearing screening are referred directly to a CCS-approved Type C Communication Disorder Center (or Level 3 Hearing and Speech Center) for a diagnostic hearing evaluation and to the local CCS program for authorization of this evaluation.

Upon identification of a hearing loss, infants and their families are referred to the local Early Start Program for access to early intervention and related services. The results of the diagnostic hearing evaluation are sent to the local CCS program so that eligibility for the program's treatment services can be determined. Subsequent to the eligibility determination, on-going audiologic services including habilitation and amplification, if chosen by the family, can be authorized.

A vital part of the NHSP is the exchange of information throughout the hearing screening process. Families will be provided informational materials that are related to the screening process, including the results of the screening. Primary care providers will receive the results of the screenings and diagnostic evaluations of infants under their care. The hospital will provide information and continuing education to medical and nursing staff regarding hearing screening.

In addition to hearing screening services, the NHSP has several other components. These include:

- An outreach and awareness campaign to provide educational information to the public and health care professionals.

- Hearing Coordination Centers (HCCs) which assist hospitals in developing their screening programs, certify and monitor the screening programs, and track those infants who require further screening and intervention to assure that they are linked to appropriate services. Each HCC has a geographic service area for which it is responsible.

- Data collection, tracking and management.

The NHSP does not mandate a specific technology to perform the newborn hearing screening. Evoked potential or otoacoustic emission testing instruments approved by the Food and Drug Administration that detect a mild hearing loss in a newborn or infant are acceptable.

Reimbursement is available from Medi-Cal for hearing screening services provided to newborns and infants eligible for the program or from the CCS program for newborns who are uninsured. Providers who have been certified to provide newborn hearing screening services may submit claims for services in accordance with the procedures outlined in this manual.

For purposes of the NHSP, "uninsured" means that the newborn or infant had no evidence of health insurance:

1. For the hospital stay during which the inpatient hearing screening was performed.

2. At the time the outpatient hearing screening or rescreening was performed.

Certification - What It Means

Inpatient Infant Hearing Screening Providers

All CCS-approved hospitals with licensed birthing facilities and all hospitals with CCS-approved NICUs must develop their own inpatient hearing screening program based on the standards described in Chapter 3.42.1 of the CCS Manual of Procedures. The standards address many areas such as:

- Staffing, including competency testing of individuals conducting the hearing screening
- Facility requirements, including the use of appropriate newborn hearing screening equipment
- Services, including information distribution to parents and primary care providers
- Care coordination and referral
- Data collection and reporting

Hospitals that are in compliance with these standards will be certified as inpatient infant hearing screening providers and receive a copy of this manual. Certification allows providers to bill the Medi-Cal and CCS programs for hearing screening services provided on or after the effective date of certification and in accordance with the guidelines contained in this manual.

The certification process for hospitals and NICUs was initiated in Spring 2000 with full participation required by all CCS-approved hospitals and NICUs by December 31, 2002. The certification process is conducted by the HCC serving the geographic service area in which the hospital is located.

Outpatient Infant Hearing Screening Providers

To participate in the NHSP, outpatient providers of hearing screening services must be certified as being in compliance with the standards described in Chapter 3.42.2 of the CCS Manual of Procedures. Certified outpatient providers will be able to bill the Medi-Cal or CCS programs for eligible newborns and infants who received hearing screening services on or after the effective date of certification. The certification process for outpatient infant hearing screening providers is conducted by CMS Branch staff.

SECTION 1.2 - REIMBURSEMENT REQUIREMENTS

Prior Authorization

Prior authorization is not required for inpatient or outpatient infant hearing screening or rescreening services.

Prior authorization is required for diagnostic hearing evaluations. For information regarding prior authorization requirements for diagnostic hearing evaluations, please refer to the section in this manual titled "Referral For Diagnostic Hearing Evaluation."

Procedure Codes

Claims for reimbursement must include the appropriate procedure code listed on the following pages when billing for newborn hearing screening services.

☝Reminder:	Prior to rendering services and submitting a claim, providers are responsible for determining what hearing screening services the newborn or infant may have already received.

PROCEDURE CODE Z9725

Procedure Code	Description	Policy
Z9725	Initial Infant Hearing Screening - Hospital/Inpatient	(1) Used to bill for hearing screening services provided to: • Newborns during their birth admission in a NHSP-certified hospital; • Newborns or infants receiving care in a CCS-approved NICU in an NHSP-certified NICU; • Newborns or infants transferred to an NHSP-certified hospital from another hospital who did not receive a hearing screening prior to the transfer. (2) Initial inpatient infant hearing screening is complete when the newborn or infant: • Passes the first bilateral screening; • Does not pass the initial screening in one or both ears but passes the repeat screening in both ears; or • Does not pass the initial and repeat screening in one or both ears. (3) Includes the repeat hearing screening performed as part of the initial inpatient hearing screening service during the newborn's or infant's admission to the hospital. (4) Payable on a fee-for-service basis **ONLY** to NHSP-certified hospitals. This service is not included in the capitation rate paid to Medi-Cal Managed Health Care Plans or in the negotiated hospital reimbursement paid to hospitals participating in the Selective Provider Contracting Program. (5) Payable once per hospital stay for the same newborn or infant. (6) Claims with dates of service for initial inpatient infant hearing screening performed after the infant is 12 months of age are not payable. (7) Claims are only payable for dates of service on or after the effective date of the provider's certification under the NHSP.

PROCEDURE CODE Z9726

Procedure Code	Description	Policy
Z9726	Initial Infant Hearing Screening - Outpatient	(1) Used to bill for hearing screening services provided by outpatient infant hearing screening providers. (2) Used to bill for those infants born in a CCS-approved hospital or receiving care in a CCS-approved NICU who were discharged from the hospital before initial inpatient hearing screening services were offered or provided. (3) Initial outpatient infant hearing screening is complete when the newborn or infant: • Passes the initial outpatient screening in both ears; or • Does not pass the initial outpatient screening in one or both ears. (4) Payable on a fee-for-service basis **ONLY** to NHSP-certified providers. This service is not included in the capitation rate paid to Medi-Cal Managed Health Care Plans. (5) Payable **ONLY** if procedure code Z9725 has not been billed. (6) Claims with dates of service for initial outpatient infant hearing screening performed after the infant is 12 months of age are not payable. (7) Claims are only payable for dates of service on or after the effective date of the provider's certification under the NHSP.

Procedure Code	Description	Policy
Z9727	Infant Hearing Rescreening - Outpatient	(1) Used to bill for hearing screening services provided by outpatient infant hearing screening providers. (2) Used to bill for those newborns or infants who did not pass the initial inpatient infant hearing screening in one or both ears. (3) Rescreening is complete when the newborn or infant: • Passes the outpatient hearing rescreening in both ears; or • Does not pass the outpatient hearing rescreening in one or both ears. (4) Payable on a fee-for-service basis **ONLY** to NHSP-certified providers. This service is not included in the capitation rate paid to Medi-Cal Managed Health Care plans. (5) Payable only once for the same newborn or infant, regardless of eligible provider. (6) Not payable if procedure code Z9726 has been paid. (7) Claims with dates of service for outpatient infant hearing rescreening performed after the infant is 12 months of age are not payable. (8) Claims are only payable for dates of service on or after the effective date of the provider's certification under the NHSP.

SECTION 1.3 - BILLING

Proper and timely submission of claims is of the highest importance. Delayed or improperly prepared claims could result in delayed payment or possible denial. Providers billing for patients who are Medi-Cal eligible or who are uninsured must adhere to the following specific instructions when completing the claim form and other applicable instructions described in the *CCS/GHPP Provider Manual* and the *Medi-Cal Provider Manual*.

Provider Number

For billing NHSP services rendered to Medi-Cal eligible newborns and infants, providers must use their outpatient Medi-Cal provider number.

For billing NHSP services rendered to uninsured newborns and infants, providers must use their outpatient "CGP" provider number. Providers who do not have an outpatient "CGP" number should contact the following office:

Department of Health Services
Children's Medical Services Branch
ATTN: CCS/GHPP Provider Enrollment
P.O. Box 997413 MS 8100
Sacramento, CA 95899-7413

Telephone: (916) 322-8702
FAX: (916) 322-8798

☝ Reminder	Providers who wish to change the Medi-Cal outpatient provider number or outpatient "CGP" number that they are using to bill inpatient or outpatient hearing screening services must send a written request to: Department of Health Services Children's Medical Services Branch Newborn Hearing Screening Program P.O. Box 997413 MS 8103 Sacramento, CA 95899-7413

Claim Forms

Providers are required to bill for services on the appropriate claim forms. Listed below are the forms to be used by procedure code. Examples of completed claim forms are located in the Appendix of this manual.

Procedure Code	Claim Form	Provider Number
Z9725	UB92	• Hospital outpatient Medi-Cal or outpatient "CGP" provider number • Los Angeles County Waiver hospitals use Medi-Cal "LAW" provider prefix
Z9726	*HCFA 1500	Outpatient Medi-Cal or outpatient "CGP" provider number
Z9727	*HCFA 1500	Outpatient Medi-Cal or outpatient "CGP" provider number

***Exception: Hospitals must ALWAYS use the UB92 claim form whether they are billing for inpatient or outpatient NHSP services. All other NHSP outpatient providers must use the HCFA 1500 claim form for billing for NHSP outpatient services.**

Place of Service

For all procedure codes, enter "7" (other) in the Place of Service field.

The following applies to the UB92 claim form only. The Medi-Cal Inpatient/Outpatient Provider Manual, which must be used in conjunction with this NHSP Provider Manual, requires that if you enter a “7” in the Place of Service field, you must enter an explanation in the Remarks field (Section 84 of the UB92 form). Enter “Newborn Hearing Screening Program” in the Remarks field whenever you enter a “7” in the Place of Service field on the UB92 claim form.

UB92 Claim Form – Remarks Field

When billing for Inpatient Infant Hearing Screening services (Z9725), you must add the following statement to section 84, Remarks Field of the UB92 claim form: “This service is not included in the facility contracted rate.”

Los Angeles County (LAC) Waiver Hospitals

LAC Waiver Hospitals that are NHSP-certified must use the provider number prefix "LAW" when billing for the inpatient or outpatient hearing screening procedure codes listed above. This prefix is assigned by the Department when NHSP provider certification is approved and is limited to billing for NHSP services. All other billing instructions stated in this manual, the *CCS/GHPP Provider Manual* and the *Medi-Cal Provider Manual* apply to LAC Waiver Hospitals.

Reimbursement Rate

The reimbursement rate of $30.00 is payable for procedure codes Z9725, Z9726 and Z9727 in accordance with the guidelines described in this manual. The rate includes all technical and professional components of the screening procedure, related patient management, information management and documentation.

Where to Submit Claims

Claims adjudication for inpatient and outpatient hearing screening services vary based on the following:

1. Claims for newborns and infants eligible under the Medi-Cal program are submitted to EDS. Refer to the *Medi-Cal Provider Manual* for submission instructions.

2. Claims for uninsured newborns and infants (billing with CGP number) are submitted to the office listed below. Prior to submission, the provider must verify that, to the best of their knowledge, the newborn or infant is uninsured as defined under the NHSP. Send the claim to:

Department of Health Services
Children's Medical Services Branch
Newborn Hearing Screening Program
P.O. Box 997413 MS 8103
Sacramento, CA 95899-7413

SECTION 2.0 - REFERRAL FOR DIAGNOSTIC HEARING EVALUATION

Background

The CCS program is responsible for providing diagnostic services to determine the presence of a CCS-eligible condition when there is a suspicion that one exists. Hearing loss is a CCS-eligible condition and is suspected when a newborn or infant does not pass the hearing screening as defined by the NHSP. Diagnostic services are available from CCS-approved providers regardless of family income, however, the CCS program requires that families use third-party insurance coverage first before CCS funds are expended. Please see the next page for the specific information to follow regarding prior authorization requirements.

Newborns or infants who do not pass the initial outpatient hearing screening or outpatient hearing rescreening are referred to a CCS-approved Type C Communication Disorder Center (or Level 3 Hearing and Speech Center) for the diagnostic hearing evaluation.

Newborns and infants receiving care in a CCS-approved NICU who do not pass the inpatient hearing screening are also referred to a CCS-approved Type C Communication Disorder Center (or Level 3 Hearing and Speech Center) after hospital discharge when a diagnostic hearing evaluation cannot be completed during their hospital stay.

Scheduling the Appointment

It is the goal of the NHSP to identify the presence of hearing loss by three months of age. Therefore, the appointment for the diagnostic hearing evaluation should be scheduled as soon as possible after the newborn or infant does not pass the initial outpatient hearing screening or the outpatient hearing rescreening, or is discharged from the NICU.

The parents should be assisted in scheduling the appointment. This may be done by the provider who will be performing the diagnostic hearing evaluation, the provider who is making a referral for the evaluation or the hospital.

The appointment can be scheduled simultaneously with the submission of the request for prior authorization to the appropriate CCS program office.

What the Diagnostic Hearing Evaluation Includes

The diagnostic hearing evaluation includes the audiologic testing procedures necessary to determine the type, degree and configuration of hearing loss. The evaluation appointment is typically scheduled for one to two hours and may require more than one visit to complete all the testing.

SECTION 2.1 - REIMBURSEMENT REQUIREMENTS

Prior Authorization

Prior authorization is required for the diagnostic hearing evaluation just as it is for all diagnostic and treatment services covered by the CCS program.

The CCS program will respond to a request for prior authorization within five working days of receipt of the request. The authorization will be issued to a CCS-approved Type C Communication Disorder Center (or Level 3 Hearing and Speech Center) for all newborns and infants referred through the NHSP.

☝ Reminder	The CCS program will authorize the diagnostic hearing evaluation regardless of the health insurance status of the newborn or infant. The provider who will be performing the evaluation must simultaneously request prior authorization from the private health insurance carrier for newborns and infants who have such insurance. However, a denial from the insurance carrier is **NOT** required prior to requesting authorization from the CCS program.

Prior Authorization Documents Required

Providers must send the following information by mail or facsimile to the CCS program in the county where the child resides:

- A CCS application form completed and signed by the family, unless one was submitted by the referring provider.
- A completed CCS Request for Service form.
- A copy of the hearing screening results.

If providers are referring the newborn or infant to a different facility for the diagnostic hearing evaluation they must indicate on the CCS Request for Service form the name of the provider to whom the child is being referred.

SECTION 2.2 - BILLING

Procedure Codes

Providers should refer to the *Medi-Cal Provider Manual* for the appropriate procedure codes to use for billing diagnostic hearing evaluation services. The current reimbursement rates assigned to these procedure codes will apply to claims for these services.

Claim Forms

Providers should refer to the *CCS/GHPP Provider Manual* and the *Medi-Cal Provider Manual* for the appropriate claim form to use and instructions on how to complete it.

Where to Submit a Claim

Claims for diagnostic hearing evaluation services provided to newborns and infants which are authorized by the CCS program must be submitted in accordance with the instructions in the *CCS/GHPP Provider Manual* and the *Medi-Cal Provider Manual*.

Claims for diagnostic hearing evaluation services provided to newborns and infants who are not Medi-Cal eligible and who have private health insurance must be submitted to the insurance carrier prior to billing the CCS program. A denial of payment from the insurance carrier must accompany the claim submitted to CCS in order for CCS to pay the claim.

SECTION 3.0 - BILLING QUESTIONS

WHERE TO GET ASSISTANCE

For assistance in resolving policy or program matters related to the NHSP or in completing claims for hearing screening for uninsured children, providers should contact the California NHSP at 1-916-322-5794.

For assistance in completing Medi-Cal claims and all other Medi-Cal billing matters, providers should contact EDS at 1-800-541-5555.

Providers **SHOULD NOT** contact the Hearing Coordination Center with billing questions.

APPENDIX

Examples of completed claim forms

CCS Application for Services form

CCS Request for Service form

Hearing Coordination Center Directory

State and County CCS Program Office Directory

Medi-Cal Beneficiary - Inpatient Screening

REORDER FROM STANDARD REGISTER FORM NO. UB92-CA PHONE: (916) 368-1200; FAX: (916) 368-1212 — APPROVED OMB NO. 0938-0279

ANYWHERE CITY HOSPITAL
P.O. BOX 567
SACRAMENTO, CA 99999

2: EXAMPLE

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: SMITH, BABY GIRL

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 DHR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
03032000	F																

CONDITION CODES

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A B C

38

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		Initial hearing screen - IP	Z9725	030400	1	30 00		
23	001	TOTAL				30 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
O/P MEDI-CAL 7	HSP11111F				30 00	

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. -SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Elizabeth Jones	03	999887777		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
LEAVE BLANK			

OTHER DIAG. CODES

67 PRIN. DIAG CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V30.0											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 00A999999

83 OTHER PHYS. ID

OTHER PHYS ID.

84 REMARKS
Newborn Hearing Screening Program
This service is not included in the facility contracted rate.

85 PROVIDER REPRESENTATIVE: X Must be signed

86 DATE

UB-92 HCFA - 1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Uninsured - Inpatient Screening

REORDER FROM STANDARD REGISTER FORM NO. UB92-CA PHONE: (916) 368-1200; FAX: (916) 368-1212 — APPROVED OMB NO. 0938-0279

ANYWHERE CITY HOSPITAL
P.O. BOX 567
SACRAMENTO, CA 99999

2 EXAMPLE

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: SMITH, BABY BOY

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 DHR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
02022000	M																

CONDITION CODES

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A B C

38

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a					
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		Initial hearing screen - IP	Z9725	020500	1	30 00		
23	001	TOTAL				30 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
O/P MEDI-CAL 7	CGP098765				30 00	

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. -SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Susan Taylor		Leave Blank		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
LEAVE BLANK			

OTHER DIAG. CODES

67 PRIN. DIAG CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V30.00											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 00A999999

83 OTHER PHYS. ID

OTHER PHYS ID.

84 REMARKS
Newborn Hearing Screening Program
This service is not included in the facility contracted rate.

85 PROVIDER REPRESENTATIVE: X Must be signed

86 DATE

UB-92 HCFA - 1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Medi-Cal Beneficiary - Outpatient Screening

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

EXAMPLE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
( ) (Medicare #) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)

1a. INSURED'S I.D. NUMBER [FOR PROGRAM IN ITEM 1]
123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Johnson, Baby Girl

3. PATIENT'S BIRTH DATE MM 02 DD 02 YY 2000 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Betty Smith

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS
Single ( ) Married ( ) Other ( )
Employed ( ) Full-Time Student ( ) Part Time Student ( )

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ( ) YES ( ) NO

b. AUTO ACCIDENT? PLACE (State) ( ) YES ( ) NO

c. OTHER ACCIDENT? ( ) YES ( ) NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
( ) YES ( ) NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM TO MM DD YY

19. RESERVED FOR LOCAL USE
Billing under mother's Medi-Cal ID#

20. OUTSIDE LAB? ( ) YES ( ) NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V30 0
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	02 25 00	02 25 00	11		Z9727			30 00					
2													
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ( ) YES ( ) NO

28. TOTAL CHARGE $ 30 00

29. AMOUNT PAID $

30. BALANCE DUE $ 30 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Must be signed
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
John Smith, M.D.
1234 A Avenue
Sacramento, CA 11111

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
00A999999
PIN# GRP#

PLEASE PRINT OR TYPE

FORM HCFA 1500 (12-90)
~~FORM OWCP 1500~~ ~~FORM RRB 1500~~

Medi-Cal Beneficiary – Outpatient Screening Provided by a Hospital

REORDER FROM STANDARD REGISTER FORM NO. UB92-CA PHONE: (916) 368-1200; FAX: (916) 368-1212 — APPROVED OMB NO. 0938-0279

ANYWHERE CITY HOSPITAL
P.O. BOX 567
SACRAMENTO, CA 99999

2: EXAMPLE

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: SMITH, BABY GIRL

13 PATIENT ADDRESS

14 BIRTHDATE: 03032000 | 15 SEX: F | 16 MS | 17 ADMISSION DATE | 18 HR | 19 TYPE | 20 SRC | 21 DHR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	Initial hearing screen -- OP	Z9726	030400	1	30 00		
001	TOTAL				30 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
O/P MEDI-CAL 7	HSP11111F				30 00	

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. -SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Elizabeth Jones	03	999887777		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
LEAVE BLANK			

67 PRIN. DIAG CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V30.0											

OTHER DIAG. CODES

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID: 00A999999

83 OTHER PHYS. ID

OTHER PHYS ID.

84 REMARKS: Newborn Hearing Screening Program

85 PROVIDER REPRESENTATIVE: X Must be signed | 86 DATE

UB-92 HCFA - 1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Uninsured - Outpatient Screening

PLEASE DO NOT STAPLE IN THIS AREA

EXAMPLE

APPROVED OMB 0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
( ) (Medicare #) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)

1a. INSURED'S I.D. NUMBER [FOR PROGRAM IN ITEM 1]
Leave Blank

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Gonzalez, Baby Boy

3. PATIENT'S BIRTH DATE MM 02 DD 02 YY 2000 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part Time Student [ ]

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V30 0
2. ___.__
3. ___.__
4. ___.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 15 00	02 15 00	11		Z9727			30 00					
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 30 00

29. AMOUNT PAID $

30. BALANCE DUE $ 30 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Must be signed
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
John Smith, M.D.
1234 A Avenue
Sacramento, CA 11111

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIN# CGP123456 GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

FORM HCFA 1500 (12-90)
FORM OWCP 1500 FORM RRB 1500

Uninsured – Outpatient Screening Provided by a Hospital

REORDER FROM STANDARD REGISTER FORM NO. UB92-CA PHONE: (916) 368-1200; FAX: (916) 368-1212 — APPROVED OMB NO. 0938-0279

ANYWHERE CITY HOSPITAL
P.O. BOX 567
SACRAMENTO, CA 99999

2 EXAMPLE

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: SMITH, BABY BOY

13 PATIENT ADDRESS

14 BIRTHDATE: 02022000 | 15 SEX: M | 16 MS | 17 ADMISSION DATE | 18 HR | 19 TYPE | 20 SRC | 21 DHR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	Infant hearing re-screening - OP	Z9727	020500	1	30 00		
001	TOTAL				30 00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
O/P MEDI-CAL 7	CGP98765				30 00	

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. -SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Susan Taylor		LEAVE BLANK		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
LEAVE BLANK			

67 PRIN. DIAG CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V30.00											

OTHER DIAG. CODES

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS ID.

84 REMARKS: Newborn Hearing Screening Program

85 PROVIDER REPRESENTATIVE: X Must be signed — 86 DATE

UB-92 HCFA - 1450 — OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form **or** whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income; or the child has Healthy Families coverage.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost; or
- have Healthy Families coverage.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

- complete the application form on page 3 and return it to their county CCS office;
- give CCS all of the information requested so CCS can determine if the family qualifies;
- apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

- CCS must keep this information confidential.[2]
- CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes

1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term **"applicant"** means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by	
2. Date of birth (month, day, year)	3. Place of birth—county and state	Country, if born outside the U.S.	
4. Applicant's residence address (number, street) (do not use a P.O. box)	City	County	ZIP code
5. Gender ☐ Male ☐ Female	6. Race/ Ethnicity	7. Social security number (optional)	
8. What is the applicant's suspected eligible CCS condition or disability?			
9. Name of applicant's physician		10. Physician's phone number ( )	

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name	
13. Residence address (number, street) (do not use a P.O. box)	City	County	ZIP code
14. Mailing address (if different from 13)		City	ZIP code
15. Day phone number ( )	16. Evening phone number ( )	17. Message phone number ( )	18. What language do you speak at home?

C. Health Insurance Information

19. Does the applicant have Medi-Cal? ☐ Yes ☐ No	If yes, what is the applicant's Medi-Cal number?	Is there a share-of-cost? ☐ Yes ☐ No	If yes, what amount do you pay per month? $
20. Is the applicant enrolled in the Healthy Families program? ☐ Yes ☐ No	If yes, what is the name of the plan?		
21 Does the applicant have other health insurance? ☐ Yes ☐ No	If yes, what is the name of the insurance plan or company?		
Type of insurance plan or company ☐ Preferred Provider (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other:_____			
22. Does the applicant have dental insurance? ☐ Yes ☐ No	23. Does the applicant have vision insurance? ☐ Yes ☐ No		

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

___ I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program.

___ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

___ I certify that I have read and understand the information or have had it read to me.

___ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date
Signature of witness (only if the person signed with a mark)		Date

Mail this form to your county CCS office.

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office (see page 6). Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. box.
5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write down the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Daytime phone number:** Please write the phone number where you can be reached during the day.
16. **Evening phone number:** Please write the phone number where you can be reached during the evening.
17. **Message phone number:** Please write your message phone number if applicable.
18. **Language(s) spoken:** Write down the language you speak **at home**.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

19. If the applicant does not receive Medi-Cal, check “No” and go to number 20. If the applicant receives Medi-Cal, check “Yes” and fill in the applicant’s Medi-Cal number. If you pay a portion of the cost of your Medi-Cal insurance, check “Yes” and fill in the amount of your shared cost. If you don’t, check “No” and go to number 20.
20. If the applicant receives health insurance from the Healthy Families program please check “Yes” and fill in the name of the plan. If the applicant does not, check “No.” Healthy Families is a special health insurance program for moderate to low income families. If you think you might qualify, you can ask your county CCS program about how to apply for the Healthy Families program.
21. If the applicant does not have other health insurance, check “No” and go to number 22. If the applicant has health insurance, check “Yes” and fill in the name of the insurance plan or company. Then check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.
22. If the applicant has dental insurance, check “Yes.” If the applicant does not have dental insurance, check “No.”
23. If the applicant has vision insurance, check “Yes.” If the applicant does not have vision insurance, check “No.”

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under “Relationship to the applicant,” enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhs.ca.gov/ccs or look in the government section of your local telephone directory under California Children’s Services or county health department.

INFORMACIÓN SOBRE LOS SERVICIOS PARA LOS NIÑOS DE CALIFORNIA (CCS)

¿Qué son los Servicios para los Niños de California?

CCS es un programa estatal que trata a niños con ciertas limitaciones físicas y con problemas y enfermedades de salud crónicos. CCS puede autorizar y pagar el costo de servicios y equipos médicos específicos provistos por especialistas aprobados por CCS. El Departamento de Servicios de Salud de California administra el programa CCS. Los condados de mayor tamaño operan sus propios programas CCS, mientras que los condados de menor tamaño comparten la operación de su programa con las oficinas regionales estatales de CCS en Sacramento, San Francisco y Los Angeles. El programa está financiado con fondos provenientes de impuestos estatales, del condado y federales, y con algunos honorarios que pagan los padres.

¿Qué ofrece CCS a los niños?

Si usted o el médico de su hijo piensa que su hijo puede tener un problema médico que cumple con los requisitos de CCS, es posible que CCS pague o provea una evaluación médica para determinar si el problema de su hijo está cubierto.

Si su hijo cumple con los requisitos, CCS podrá pagar o brindar:

- Tratamiento, como servicios médicos, cuidados en el hospital y de cirugía, fisioterapia y terapia ocupacional, pruebas de laboratorio, radiografías, aparatos ortopédicos y equipo médico.
- Manejo de casos médicos para ayudar a obtener médicos especialistas y cuidados para su hijo si son médicamente necesarios, así como remisión a otros organismos, incluyendo enfermería de salud pública y centros regionales.
- Programa de Terapia Médica (MTP, por sus siglas in inglés), que puede prestar servicios de fisioterapia y/o de terapia ocupacional en escuelas públicas para niños que cumplen con ciertos requisitos médicos.

¿Quiénes cumplen con los requisitos para CCS?

El programa está a disposición de todos los que:

- son menores de 21 años de edad;
- tienen o pueden tener un problema médico cubierto por CCS;
- son residentes de California y
- tienen un ingreso familiar de menos de $40,000, según se informe en el ingreso bruto ajustado del formulario impositivo del estado **o** se **espera** que tendrán gastos médicos de bolsillo, para un niño que cumple con los requisitos, de más del 20 por ciento del ingreso familiar; o bien, el niño tiene cobertura de Healthy Families.

El ingreso familiar no es un factor determinante en el caso de los niños que:

- necesitan servicios diagnósticos para confirmar un problema médico que cumple con los requisitos de CCS; o
- fueron adoptados con conocimiento de que tenían un problema médico que cumple con los requisitos de CCS; o
- sólo están solicitando servicios mediante el Programa de Terapia Médica; o
- tienen Medi-Cal completo, sin compartir el costo; o
- tienen cobertura de Healthy Families.

¿Qué problemas médicos cubre CCS?

Sólo ciertos problemas están cubiertos por CCS. En general, CCS sólo cubre problemas médicos que causan impedimentos físicos o requieren servicios médicos, quirúrgicos o de rehabilitación. También puede haber ciertos criterios que determinan si el problema médico de su hijo cumple con los requisitos. La lista a continuación contiene las categorías de problemas médicos que pueden estar cubiertos y **algunos ejemplos** de cada uno de ellos:

- Problemas del corazón (enfermedad cardíaca congénita)
- Neoplasmas (cánceres, tumores)
- Enfermedades de la sangre (hemofilia, anemia de células falciformes)
- Enfermedades endocrinas, de nutrición y metabólicas (problemas de tiroides, PKU [fenilcetonuria], diabetes)
- Enfermedades del sistema genito-urinario (problemas crónicos serios de los riñones)
- Problemas del sistema gastrointestinal (enfermedad inflamatoria crónica, enfermedades del hígado)
- Defectos de nacimiento serios (paladar hendido, labio leporino, espina bífida)
- Enfermedades de los órganos sensoriales (pérdida del oído, glaucoma, cataratas)
- Enfermedades del sistema nervioso (parálisis cerebral, ataques no controlados)
- Enfermedades del sistema musculosquelético y de los tejidos conectivos (artritis reumatoide, distrofia muscular)
- Enfermedades graves del sistema inmune (infección por el VIH)

- Problemas que causan impedimentos o intoxicaciones que requieren cuidados intensivos o rehabilitación (lesiones graves de la cabeza, el cerebro o la médula espinal, quemaduras graves)
- Complicaciones del nacimiento prematuro que requieren cuidados intensivos
- Enfermedades de la piel y del tejido subcutáneo (hemangioma grave)
- Mala oclusión que causa impedimentos médicos (dientes muy torcidos)

Si tiene preguntas, la oficina CCS de su condado se las puede responder.

¿Qué tiene que hacer el solicitante o la familia para cumplir con los requisitos?

Las familias (o el solicitante, si cumplió los 18 años o es un menor de edad emancipado) deben:

- completar el formulario de solicitud en la página 3 y enviarlo a la oficina CCS de su condado;
- dar a CCS toda la información solicitada, para que CCS pueda determinar si la familia cumple con los requisitos;
- solicitar Medi-Cal si CCS cree que el ingreso de la familia la habilita para registrarse en el programa Medi-Cal. (Si una familia califica para Medi-Cal, el niño también está cubierto por CCS. CCS aprueba los servicios y los pagos se efectúan mediante Medi-Cal).

¿Cómo se protege mi privacidad?

La ley de California requiere que se dé a las familias que soliciten servicios información sobre cómo CCS protege su privacidad.[1]

Para proteger su privacidad:

- CCS tiene que mantener esta información confidencial.[2]
- CCS puede compartir la información que figura en el formulario con personal autorizado de otros programas de salud y bienestar **únicamente** si usted firmó un formulario de consentimiento.

Usted tiene derecho a ver su solicitud y los datos de CCS relativos a usted o a su hijo. Si desea ver estos datos, póngase en contacto con la oficina CCS de su condado. Por ley, la información que usted da a CCS es archivada por el programa.[3]

¿Tengo derecho a apelar una decisión?

Tiene derecho a estar en desacuerdo con las decisiones que tome CCS.[4] Esto se llama hacer una apelación. El proceso de apelación permite que el padre, el tutor o el solicitante trabaje con el programa CCS para encontrar soluciones a los desacuerdos. Para información sobre el proceso de apelación, póngase en contacto con la oficina CCS de su condado.

¿Dónde puedo obtener más información sobre CCS?

Para más información o ayuda para llenar esta solicitud, póngase en contacto con la oficina CCS de su condado. Por lo general, el número de teléfono de dicha oficina figura en la sección de gobierno del directorio telefónico local. Busque bajo *California Children's Services* (Servicios para los Niños de California) o *County Health Department* (Departamento de Salud del condado).

Notas

1 Código Civil, Sección 1798.17
2 De conformidad con la Sección 41670, Título 22, Código de Reglamentaciones de California y la ley de Datos Públicos de California (Código de Gobierno, Secciones 6250–6255)
3 Sección 123800 et. seq. del Código de Salud y Seguridad de California
4 Código de Reglamentaciones de California, Título 2, Secciones 42702–42703

SOLICITUD PARA DETERMINAR SI EL SOLICITANTE PUEDE PARTICIPAR EN EL PROGRAMA CCS

Esta solicitud debe ser completada por el padre, el tutor o el solicitante (si cumplió los 18 años de edad o es un menor de edad emancipado) para determinar si el solicitante cumple con los requisitos para recibir servicios y beneficios de CCS. El término **"solicitante"** significa el niño, la persona de 18 años de edad o más o el menor de edad emancipado para el que se solicitan los servicios. Para obtener instrucciones sobre cómo completar este formulario, consulte la página 4. Escriba a máquina o claramente en letras de molde.

A. Información sobre el solicitante

1. Nombre del solicitante [apellido] [nombre] [segundo nombre]	Nombre en el certificado de nacimiento (si es diferente)	Algún otro nombre por el que se conoce al solicitante
2. Fecha de nacimiento (mes, día, año) _____ / _____ / _____	3. Lugar de nacimiento, condado y estado	País, si nació fuera de EE.UU.
4. Dirección del solicitante (número y calle) (no usar casilla postal)	Ciudad	Condado / Código postal
5. Género ☐ Masculino ☐ Femenino	6. Raza/ etnia	7. Número del seguro social ***(optativo)*** __ __ __ - __ __ - __ __ __ __
8. ¿Cuál es el problema o la discapacidad del solicitante que se sospecha que cumple con los requisitos de CCS?		
9. Nombre completo del médico del solicitante		10. Número de teléfono del médico ( )

B. Información sobre el padre o tutor (los solicitantes de 18 años de edad o mayores o los menores emancipados saltean los números 11 y 13).

11. Nombre(s) completo(s) del/de los padre(s) o tutor(es)	12. Nombre de la madre (si no se identificó en 11)	Apellido de soltera
13. Dirección (número y calle) (no usar casilla postal)	Ciudad	Condado / Código postal
14. Dirección postal (si no es la misma que la del 13)		Ciudad / Código postal
15. Nº de teléfono diurno ( )	16. Nº de teléfono nocturno ( )	17. Nº para mensajes telefónicos ( ) / 18. ¿Qué idioma se habla en su casa?

C. Información sobre el seguro de salud

19. ¿Tiene Medi-Cal el solicitante? ☐ Sí ☐ No	Si tiene, ¿cuál es el número de Medi-Cal del solicitante?	¿Comparte el costo? ☐ Sí ☐ No	Si lo comparte, ¿cuánto paga por mes? $
20. ¿Está inscrito el solicitante en el programa Healthy Families? ☐ Sí ☐ No	Si lo está, ¿cómo se llama el plan?		
21. ¿Tiene el solicitante otro seguro de salud? ☐ Sí ☐ No	Si lo tiene, ¿cómo se llama el plan o la compañía de seguros?		
Tipo de plan o compañía de seguros ☐ Proveedor Preferente (PPO) ☐ Organización para el Mantenimiento de la Salud (HMO) ☐ Otro:_____			
22. ¿Tiene seguro dental el participante? ☐ Sí ☐ No	23. ¿Tiene seguro de la vista el solicitante? ☐ Sí ☐ No		

D. Certificación (Coloque sus iniciales y firme a continuación. Su firma autoriza al programa CCS a proceder con esta solicitud).

___ Solicito el programa CCS para determinar el cumplimiento de requisitos para obtener servicios y beneficios. Entiendo que completar esta solicitud no garantiza la aceptación del solicitante en el programa CCS.

___ Doy permiso para que se verifique mi dirreción, información sobre la salud u otras circunstancias que se requieran para determinar el cumplimiento de requisitos para recibir servicios y beneficios CCS.

___ Certifico que he leído y comprendo la información o que me la han leído.

___ También certifico que la información que escribí en este formulario es verdadera y correcta.

Firma de la persona que llenó la solicitud	Relación con el solicitante	Fecha
Firma del testigo (sólo si la persona firmó con una marca)		Fecha

Envíe este formulario por correo a la oficina CCS de su condado. Consulte la página 6 para obtener una lista de direcciones.

INSTRUCCIONES PARA COMPLETAR EL FORMULARIO PARA SOLICITAR SERVICIOS PARA NIÑOS DE CALIFORNIA (DHS 4480)

Escriba claramente en letras de molde para que su solicitud se pueda tramitar lo más rápidamente posible.

Llene cada sección completamente. Si no da toda la información, CCS no podrá proceder con su solicitud. Si necesita ayuda para llenar este formulario, póngase en contacto con la oficina CCS de su condado.

Después de completar la solicitud, envíela por correo a la oficina CCS de su condado (consulte la página 6). No olvide firmar el formulario y colocarle la fecha.

Sección A: Información sobre el solicitante ("Solicitante" significa el niño, la persona de 18 años de edad o mayor, o el menor de edad emancipado para el que se solicitan los servicios).

1. **Nombre del solicitante:** Escriba el apellido, el nombre y el segundo nombre del solicitante. En la casilla que sigue, escriba el nombre completo del solicitante como aparece en su certificado de nacimiento si no es igual a su nombre. Si el solicitante se conoce por cualquier otro nombre, escriba ese nombre en la última casilla.
2. **Fecha de nacimiento del solicitante:** Escriba el mes, el día y el año del nacimiento del solicitante.
3. **Lugar de nacimiento:** Escriba el condado y el estado en los que nació el solicitante. Si el solicitante nació fuera de EE.UU., escriba el país.
4. **Dirección:** En este espacio, escriba el número de la calle, el nombre de la calle, el número del departamento, la ciudad, el condado y el código postal del lugar donde vive ahora el solicitante. No use ninguna casilla de correo.
5. **Género del solicitante:** Ponga una marca Ö o una **X** en la casilla que corresponda al género (masculino o femenino).
6. **Raza o etnia:** Ponga la categoría de la lista que aparece más abajo que mejor describa la raza o etnia principal del solicitante:

- Nativo de Alaska
- Amerasiático
- Indígena norteamericano
- Asiático
- Indio asiático
- Negro/afronorteamericano
- Camboyano
- Chino
- Filipino
- Guaymeño
- Hawaiano
- Hispano/latino
- Japonés
- Coreano
- Laosiano
- Samoano
- Vietnamita
- Blanco
- Otro

7. **Número del seguro social del solicitante (optativo):** Escriba el número de nueve cifras del seguro social del solicitante.
8. **Problema o discapacidad que se sospecha que cumple con los requisitos de CCS:** Escriba la discapacidad o la necesidad especial de atención de la salud del solicitante que trataría el CCS. La descripción adjunta de los problemas que cumplen con los requisitos de CCS lo puede ayudar (consulte "¿Qué problemas médicos cubre CCS?" en la página 1). Si no sabe, pregunte al médico del solicitante o deje el espacio en blanco. Si hace falta más información, CCS se pondrá en contacto con el médico del solicitante.
9. **Nombre completo del médico del solicitante:** Escriba el nombre completo del médico del solicitante.
10. **Número de teléfono del médico:** Escriba el número de teléfono del médico que puso en el número 9.

Sección B: Información sobre el padre o tutor (Los solicitantes de 18 años de edad o mayores o los menores de edad emancipados saltean los números 11 y 13).

11. **Nombres completo(s) del/de los padre(s) o tutor(es):** Escriba el/los nombre(s) del/de los padre(s) del solicitante o del/de los tutor(es) del solicitante.
12. **Nombre y apellido de soltera de la madre:** Escriba el nombre y el apellido de soltera de la madre del solicitante.
13. **Dirección:** Escriba el número de la calle, el nombre de la calle, el número del departamento, la ciudad, el condado y el código postal del lugar en que usted vive ahora. No use ninguna casilla de correo.
14. **Dirección postal:** Si la dirección es diferente de la del número 13, escriba el número de la calle, el nombre de la calle, la ciudad y el código postal.
15. **Número de teléfono diurno:** Escriba el número de teléfono al que se lo puede llamar durante el día.
16. **Número de teléfono nocturno:** Escriba el número de teléfono al que se lo puede llamar durante la noche.
17. **Número para mensajes telefónicos:** Si corresponde, escriba el número de teléfono para dejarle mensajes telefónicos.

18. **Idioma(s) que habla:** Escriba el idioma que usted habla **en su casa**.

Sección C: Información sobre el seguro de salud

Si CCS cree que usted puede cumplir con los requisitos de participación, le pedirán que solicite Medi-Cal si en la actualidad no está recibiendo beneficios Medi-Cal para la atención de la salud.

19. Si el solicitante no recibe Medi-Cal, marque “No” y pase al número 20. Si el solicitante recibe Medi-Cal, marque “Sí” y escriba el número de Medi-Cal del solicitante. Si usted paga una parte del costo de su seguro Medi-Cal, marque “Sí” y escriba la cantidad del costo que comparte. De lo contrario, marque “No” y pase al número 20.
20. Si el solicitante recibe seguro de salud del programa Healthy Families, marque “Sí” y escriba el nombre del plan. Si el solicitante no recibe ese seguro, marque “No”. Healthy Families es un programa de seguro especial para las familias de ingresos moderados a bajos. Si le parece que puede cumplir con los requisitos, pregúntele al programa CCS de su condado cómo puede solicitar participar en el programa Healthy Families.
21. Si el solicitante no tiene otro seguro de salud, marque “No” y pase al número 22. Si el solicitante tiene seguro de salud, marque “Sí” y escriba el nombre del plan o de la compañía de seguros. Después marque la casilla que corresponda, dependiendo de la clase de seguro que sea. Sus formularios de seguros le indican la clase de seguro de salud que tiene. Si no está seguro puede llamar a su compañía de seguros y preguntarles.
22. Si el solicitante tiene seguro dental, marque “Sí”. Si el solicitante no tiene seguro dental, marque “No”.
23. Si el solicitante tiene seguro de la vista, marque “Sí”. Si el solicitante no tiene seguro de la vista, marque “No”.

Sección D: Certificación

Asegúrese de firmar y poner la fecha con tinta. Si firma con una marca, pida a un testigo firme y ponga la fecha.

En la sección “Relación con el solicitante”, coloque padre, madre, tutor o sí mismo (en el caso de las personas de 18 años de edad o mayores, de los menores de edad emancipados).

Presentación de su solicitud

Envíe por correo o entregue su solicitud a la oficina CCS de su condado. Para encontrar la oficina CCS de su condado visite www.dhs.ca.gov/ccs o busque en la sección de gobierno del directorio telefónico local bajo *California Children’s Services* (Servicios para los Niños de California) o *County Health Department* (Departamento de Salud del condado).

CALIFORNIA CHILDREN SERVICES (CCS) PROGRAM
Request for Service Form
Newborn Hearing Screening Program (NHSP) Referral

This form is to be completed by a health care provider who is seeking approval for health care services (including hospital inpatient stays) from the CCS program for a potential CCS applicant or CCS client. When this is an initial request for services, it also constitutes a referral to the program. Items identified with an " ✓ " and in **BOLD** denote required data fields which must be completed if further action is to be taken.

✓ **PATIENT INFORMATION** CCS Number (if known): _____ CIN No._____		**DATE:**
✓ **PATIENT'S NAME & ADDRESS**	✓ **DATE OF BIRTH**: / /	✓ PARENT(S)/LEGAL GUARDIAN NAME & ADDRESS
	GENDER: Male ❒ Female ❒	
PATIENT'S BIRTH CERTIFICATE NAME (if different than name given)	SOCIAL SECURITY NUMBER:	
PATIENT'S PLACE OF BIRTH (City, County and State)	COUNTY OF RESIDENCE:	✓ **HOME PHONE NUMBER: ( ) -** WORK PHONE NUMBER: ( ) -

MEDI-CAL? ❒ YES ❒ NO ❒ UNKNOWN If YES, Medi-Cal Number: If YES, is child in Managed Care Plan? ❒ YES ❒ NO If YES, Name of Plan: _____	MEDICAL INSURANCE? ❒ YES ❒ NO ❒ UNKNOWN If YES, Carrier or Plan Name and Policy Number: _____ Is Insurance an HMO? ❒ YES ❒NO

HEALTHY FAMILIES: ❒ YES ❒ NO If YES, Name of Plan _____

Please complete the following two items below ONLY if this is the initial request for services for this patient.

✓**MOTHER'S FIRST NAME AND MAIDEN NAME:**	✓**ETHNIC GROUP:** ❒ Amer Indian ❒ Asian ❒ Black/African Amer ❒ Hispanic ❒ Filipino ❒ Alaskan Native ❒ White ❒ Amer Asian ❒ Japanese ❒Korean ❒Samoan ❒ Chinese ❒ Cambodian ❒ Asian Indian ❒ Hawaiian ❒ Guamanian ❒ Laotian ❒ Vietnamese ❒ No Response ❒ Unknown

REQUEST FOR SERVICES

PROVIDER TYPE: ❒ PHYSICIAN ❒ HOSPITAL ❒ OTHER HEALTH CARE PROVIDER _____

SPECIFIC SERVICES REQUESTED	PROCEDURE CODES
1. Diagnostic Hearing Evaluation	
2.	
3.	

Attach pertinent medical information related to the request. (Describe nature of medical problems, including significant associated conditions OR attach medical reports that support the requested services)

If diagnosis is known, please identify:

PRIMARY: OTHER:

SECONDARY:

PROVIDER NAME/ADDRESS:

COMPLETED BY:	PHONE NUMBER: ( ) -

TITLE:

HEARING COORDINATION CENTER (HCC) DIRECTORY

Northeastern & Central California HCC

5301 F Street, Suite 213
Sacramento, CA 95819-3295
(916) 733-7088

Bay Area/Coastal California HCC

147 Lomita Drive, Suite J
Mill Valley, CA 94941-1462
(415) 383-3752

Southern California HCC

2880 Atlantic Avenue, Suite 255
Long Beach, CA 90806
(562) 424-4757

South-Eastern California HCC

11234 Anderson Street, MVP-185
Loma Linda, CA 92354
(909) 558-3478

To find your county CCS office, go to www.dhs.ca.gov/ccs or look in the government section of your local telephone directory under California Children's Services or county Health Department.