Contracted Provider 90-Day Rule for Other Healthcare Coverage (OHC) Claims Attestation

RESET

Contracted Agency Name _____ Date _____

This form may be submitted on the 91st day to affirm it has been 90 days since the original claim date and the contracted provider has not received a response (payment/denial) from the OHC to bill Medi-Cal, as required by the Department of Health Care Services (DHCS) 90-Day Claim Rule.

Service Program Code (Reporting Unit)	Client Last Name, First Name	Client ID Number	Service Date	Service Code	OHC Claimed Date (Proof of Claim Date Required)	OHC Name	90 Day Date (from the original billing date)

This form should be submitted with a copy of the completed and dated insurance claim form. Contract provider may submit form and supporting documentation to the sFTP site.

Send an email to: DBH IT Helpdesk to create a Help Desk ticket. *The email should document this Attestation was submitted to the sFTP site, include the name of the sFTP site folder for the Service Program and File Name with reference to the date of attestation.*

Date Prepared:			
Contact Name:		Contact Phone Number:	
Contact Email:			

I attest to having formally submitted the associated documentation to DBH Revenue Cycle via your agency sFTP site at least 90 days from the date of service.

_____ _____ _____

Printed Name Signature (e-signature accepted) Date