State of California
MH 2180(1/07)

Department of Mental Health

MEDI-CAL (M/C) CERTIFICATION AND TRANSMITTAL

Part A: Provide the following information: **NPI#** _____

COUNTY SUBMITTING FORM:_____ COUNTY CODE:_____

TYPE OF TRANSACTION *(Check all that apply)* ☐ Activate ☐ Terminate ☐ Change ☐ Re-Cert

If change, indicate one or more types: ☐ Name ☐ Address ☐ Mode/SF ☐ Effective Date

PROVIDER NUMBER:_____

PROVIDER NAME:_____

PROVIDER ADDRESS:_____

PROVIDER CITY:_____ PROVIDER ZIP CODE: _____

M/C ACTIVATION DATE:_____ M/C TERMINATION DATE:_____ M/C RECERT DATE:_____

IF CHANGE, EFFECTIVE DATE OF CHANGE:_____

Per the MHP Contract, the M/C activation date cannot be earlier than the latest date of the following dates:
1) Date the site was operational:_____,
2) Date of the fire clearance:_____,
3) Date the provider requested certification:_____.
In addition, the onsite review must be within six months of these dates. Date of onsite review:_____

Is the county submitting this form, the host county? ☐*yes* ☐*no If no, name host county?*_____

Indicate services	Revenue/Procedure Code (CR/DC Mode, Service Function)			
☐ (07) General Hospital	0100 (05/10)	0101 (05/19)	☐ Non-Hospital PHF	H2013 (05/20)
☐ (08) Psych Hosp Age (< 21)	0100 (05/10)	0101 (05/19)	☐ Crisis Residential	H0018 (05/40)
☐ (09) Psych Hosp Age (> 64)	0100 (05/10)	0101 (05/19)	☐ Adult Residential	H0019 (05/65)

For Residential – How many beds? _____

Check only one Mode (either 12 or 18): ☐ *(12) Hospital Outpatient* ☐ *(18) Non-Hospital Outpatient*

Indicate services	Procedure Code (CR/DC Mode, Service Function)	(*Check all that apply*)	
☐ Crisis Stabilization ER	S9484 (10/20)	☐ Crisis Stabilization UC	S9484 (10/25)
☐ Day TX Intensive Half Day	H2012 (10/81)	☐ Day TX Intensive Full Day	H2012 (10/85)
☐ Day Rehab. Half Day	H2012 (10/91)	☐ Day Rehab. Full Day	H2012 (10/95)
☐ Case Manage./Brokerage	T1017 (15/01)	☐ MHS H2015 (15/30)	☐ TBS H2019 (15/58)
☐ Medication Support	H2010 (15/60)	☐ Crisis Intervention H2011 (15/70)	

The above named provider is certified by this agency to participate in the Short-Doyle/Medi-Cal program. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436, the terms of the contract between the MHP and the Department.

_____ County Fax: (_____)_____
Print name of person completing form.

_____Phone: (_____)_____Date: _____
Authorized Signature. Check below to indicate person signing.

☐ County Mental Health Director or Designee ☐ Medi-Cal Oversight

To be submitted to Medi-Cal Oversight for signature below.

Part B: Medi-Cal Oversight Approval to Transmit Data to DHS

_____Medi-Cal Oversight Date: _____