



**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR**

**MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION
Provider Support Office
Fee-for-Service Section**

Date:

TO: Department of Mental Health
Provider Support Office
Attn: Systems Access Unit
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

FROM: _____
Network Provider, Billing Agent/Service or Clearinghouse Name

SUBJECT: **DIRECT DATA ENTRY (DDE) APPLICATION PROCESSING CHECKLIST**
http://lacdmh.lacounty.gov/hipaa/ffs_ISForms.htm

Attached for processing are the forms required to submit claims electronically in the Integrated System via DDE.

Provider Name _____ Provider Number _____

(A) Obtaining Access

1. Applications Access Form
2. Application Access Form Attachment (For Application with additional assigned location)
3. Authorized to Sign CIOB Access
4. Confidentiality Oath
5. Downey Data Center Registration for Contractor/Vendor
6. Agreement for Acceptable Use
7. Rendering Provider Form
8. Rendering Provider Form Attachment (For Application with additional assigned location)

(B) Renewing Access

1. SecurID Token Renewal Request
2. Agreement for Acceptable Use

(C) Terminating Access

1. Applications Access Form
2. Downey Data Center Registration for Contractor/Vendor

If you have any questions or need additional information, you may contact the CIOB Helpdesk at (213) 351-1335 or the Fee-for-Service Section at (213) 738-3311 or FFS2@dmh.lacounty.gov.

Attachments _____

3/18/2014