



**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU**

MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATIONS DIVISION

Date:

TO: Marlene Shahverdian
CIOB Help Desk
695 S. Vermont Avenue, 7th Floor
Los Angeles, CA 90005

FROM: _____

SUBJECT: **__ DDE / __ EDI APPLICATION PROCESSING CHECKLIST**

Attached for processing are the forms necessary to submit claims electronically in the Integrated System via DDE only or DDE and EDI listed below:

Provider Name _____ Provider Number _____

<input type="radio"/> DIRECT DATA ENTRY ONLY	<input type="radio"/> DDE/ELECTRONIC DATA INTERCHANGE
1. Applications Access Form 3	1. Applications Access Form 3
2. MIS Confidentiality Oath	2. MIS Confidentiality Oath
3. Downey Data Center Registration	3. Downey Data Center Registration
4. SecurID Card Agree't f/Acceptable Use...(AUP)	4. SecurID Card Agree't f/Acceptable Use...(AUP)
5. Rendering Provider Registration Form	5. Rendering Provider Registration Form
6. Rendering Provider Registration Form Attachment	6. Rendering Provider Registration Form Attachment
7. Individual Authorized to Sign CIOB Forms	7. Individual Authorized to Sign CIOB Forms
8. DDE/EDI Selection General Req. Agreement	8. DDE/EDI Selection General Req. Agreement
	9. Trading Partner Agent Authorization Form
	10. Trading Partner Agreement Form
	11. Trading Partner Digital Certification Request

If you have any questions or need additional information, you may contact _____ at _____.

KSJ:ksj
Claiming Application Ltr 2 KSJ
2/28/06

Attachments _____