



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



**MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION  
 Provider Relations Unit**

Date:

TO: Department of Mental Health  
 CIOB - Attn: Systems Access Unit  
 695 S. Vermont Avenue, 8<sup>th</sup> Floor  
 Los Angeles, CA 90005

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

SUBJECT: **\_\_ DDE / \_\_ EDI APPLICATION PROCESSING CHECKLIST**

Attached for processing are the forms required to submit claims electronically in the Integrated System via DDE only or DDE and EDI. The following method is checked below:

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

<input type="checkbox"/> <input checked="" type="checkbox"/> ← DIRECT DATA ENTRY ONLY	<input type="checkbox"/> <input checked="" type="checkbox"/> ← DDE/ELECTRONIC DATA INTERCHANGE
1. Applications Access Form 3	1. Applications Access Form 3
2. Confidentiality Oath	2. 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 <b>Attachment</b> (For applicants with multiple providers)	6. Rendering Provider Registration Form <b>Attachment</b> (For applicants with multiple providers)
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	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  
 1/20/2010

Attachments \_\_\_\_\_