

Access Forms

- CIOB/Information Security Division
 - Systems Access Unit

Facilitating Form Processing

Individual Authorized To Sign CIOB Forms

➤ To meet departmental guidelines and other internal controls we require that all forms carry the signature of Program Director level or above.

- Responsible person i.e. CEO, Program Director, Deputy, etc. May also designate additional individuals to sign required forms to authorized access to the Integrated System (Data Entry) or permit service delivery staff (rendering provider) association to Legal Entity reporting unit (s).
- Form Link:
<http://dmh.lacounty.gov/hipaa/documents/Auth%20Sign%20CIOB%20Revised.pdf>

Integrated System Access

Direct Data Entry and/or Support Staff

Forms Required

- **Applications Access (AAF)**
 - allows creation of end-user profile in the IS
 - role assignments allow client searches, maintain data, medication, reports, etc.
 - provider number association restricts access to client's information by provider number association.
- **RSA SecurID Card**
 - **Downey Data Center Registration, Contractor (DDCR)**
 - Provides a securID card. Initial authentication to permit end-users through the County's Firewall.
 - **Agreement For Acceptable Use and Confidentiality of...(AUP)**
 - User acknowledgement of confidentiality and violation penalties.
- **Submit 3 forms (AAF, DDCR, and AUP) to CIOB/Information Security Division/Systems Access, 695 S. Vermont Ave, 8th Fl, LA 90005**
 - Processing time 2 to 3 weeks
 - Mail to Provider or Provider may pick-up Logon Packet
- **Confidentiality Oath**
 - Maintained by Provider
- ***To terminated services from a provider location submit an AAF, DDCR and the RSA SecurID Card.***

“IS Forms” link

http://dmh.lacounty.info/hipaa/cp_ISForms.htm

Integrated System
To Enrich Lives Through Effective and Caring Service

IS HOME DIRECTLY OPERATED CLINICS OUTPATIENT FEE-FOR-SERVICE CONTRACT PROVIDERS

Working in the IS ← → IS Forms

[Special Bulletins!](#)
[Getting Started on the IS](#)
[Getting IS Training](#)
[Using the IS](#)
[Using IS Reports](#)
[Handling Error Msgs. & Denials](#)
[IS Forms](#)
[Clinical Forms](#)
[Co-Occurring Disorders Forms](#)
[Getting Help with the IS](#)
[Links](#)
[EDI / Secure File Transfer](#)

These forms are for Contract Providers
~ [Face Sheets/Billing Forms](#) ~

[Procedures for Forms](#)

- Integrated System Access**
 - [Applications Access Form Instructions](#) rev. 6/06
 - [Applications Access Form](#) rev. 6/06 **SAMPLE**
 - [Applications Access Form Attachment](#)
 - [Applications Access Form Codes](#)
 - [Integrated System Access Roles](#) rev. 01/10/07
- Authorization to Sign CIOB Access Forms** rev. 1/10 **SAMPLE**
[DMH Policy 302.18](#) on "Security and Integrity of the Department's IS"
[Confidentiality Oath](#) ~ **SAMPLE**
[Downey Data Center Registration/Non-County](#) rev. 03/10 **SAMPLE**
[IS Connection Options](#)
- SecurID Renewal Non County and AUP** and [Sample Form and Sample AUP](#)
[Request for Replacement of Lost PIN](#)
[Request to Change Funding Source on COS](#)

- Service Delivery Staff**
 - [Rendering Provider Form PDF](#) rev. 3/14

Link to Data Entry Staff Forms:
http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

Required forms, instructions, codes, roles and other helpful information are listed under Integrated System Access.

Sample

Sample Applications Access Form

Form #1
Data Entry Staff


Applications Access (AAF)

- allows creation of end-user profile in the IS
- role assignments allow client searches, maintain data, medication, reports, etc.
- provider number association restricts access to client's information by provider number association.

Required Signatures :

- User
- Authorized Manager or designee

SUPPORT STAFF Requiring Data Entry Access



APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
CHIEF INFORMATION OFFICE BUREAU

REQUEST TYPE

Effective Date: 1/15/2004

Add New User Information Update Add Reporting Unit Add Role Termination

Transfer Delete Reporting Unit Delete Role Name Change

Temporary Pharmacy FFS NSA DHS

EMPLOYEE STATUS

Permanent Temporary Pharmacy FFS NSA DHS

APPLICANT INFORMATION

Employee No. (County Only): [] Last Name: SNOWHITE First Name: CHIEF MI: [] Last 4 Digits of SSN: 1058

Date of Birth MM/DD: 09/05 Sex Code: F Ethnicity Code: 03 Handicap Code: 00 Language Code: 01 Name of Facility / Bureau / FFS Network Provider / Pharmacy: SELOVED MEDICAL CENTER

Program Name / Unit: PSYCH EMERGENCY Address: 1114 SANRAVE BLVD Suite / PL: 901

City: SANFEE CITY State: CA Zip Code: 91234 Phone Number: [] E-Mail Address: HOWARD@MHSOHP.ORG

ROLE CLN01 CLN02 RPTPROV

SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

DMH Provider No.: 1234A NSA Legal Entity No.: 1123

DHS Provider No.: [] Pharmacy: [] FFS Provider No. (*): []

SELECT APPLICATION ACCESS

Integrated System: One Treatment Authorization STAR MAA MED6 []

Oath of Confidentiality on file at Facility: Original Oath Attached with MED6 Request:

SIGNATURES

Applicant Print Name: CHIEF SNOWHITE Signature: SIGNATURE REQUIRED Date Completed: 01/15/04

Contact Print Name: MARY SNOWHITE Phone Number: 311-266-0113 Date Completed: 01/15/04

Program Head / Authorized Designee Print Name: DR. SALLY SNOWHITE Signature: SIGNATURE REQUIRED Date Completed: 01/15/04

FOR CIOB USE ONLY

User ID: [] HEAT Call Ticket: [] Date Received: []

Processed By: [] Remarks: [] Date Completed: []

Having problems filling out this form? Call CIO-Desktop at 213-365-1336 Revised: 03/07/2006 Please return to: Department of Mental Health
CIOB - Systems Access, 8th Fl
585 S. Vermont Ave.
Los Angeles, CA 90005

(*): Please use Form MH1003 for additional locations.

Blank form can be downloaded from the IS link.

This Sample indicates required Information: (All fields)

Downey Data Center Registration Form

Form #2
Data Entry Staff

LOS ANGELES COUNTY
ISD
INTEGRATED SERVICES

COUNTY OF LOS ANGELES
DOWNY DATA CENTER REGISTRATION
For Contractors/Vendors

S A M P L E

PROFILE INFORMATION print or type completing boxes 1 - 9

(1) DATE OF REQUEST 7/15/2010 (2) TYPE OF REQUEST (Check One) ADD NEW LOGON ID REPLACE LOST/STOLEN SECUREID TOKEN (3) CONTRACT OR VENDOR NUMBER

(4) LAST NAME, FIRST NAME AND (5) E-MAIL ADDRESS
NEVERWRONG, SAMPLE A. SNEVERWRONG@PLENT.COM

(6) COMPANY/ORGANIZATION NAME PLENTY MHS (7) COORDINATING L.A. COUNTY DEPARTMENT NAME / NUMBER
MENTAL HEALTH - #435

(8) WORK MAILING ADDRESS (STREET, CITY, STATE, ZIP) 2345 Happy Street, Cherry Blossom, CA 90021 (9) WORK PHONE NUMBER 213 201-2000

IBM DATA CENTER ACCESS complete each area for required access, as defined by L.A. County management

(10) LOGON ID (11) 2-DIGIT MAJOR GROUP CODE HQ (12) 2-DIGIT LSO GROUP CODE MH

TSO ACCESS — check box and complete for required access, as defined by L.A. County management. Asterisks are optional data.
(13) 2-DIGIT TSO GRP CODE (14) SUB-GROUP 1* (15) SUB-GROUP 2* (16) SUB-GROUP 3*

ONLINE ACCESS — check box and complete for required access, as defined by County management. Asterisks are optional data.
(17) SYSTEM APPLICATION IS (18) GRP NAME / NATURAL PROFILE (19) OLD GRP/NATURAL PROFILE* DMV/VALEPS APPLICATION COORDINATORS ONLY
APR AID: _____
DMV SYSTEM CODE: _____
APR ENVIRONMENT LOCATION: _____

UNIX ENVIRONMENT ACCESS complete for required access, as defined by L.A. County management.

(20) TYPE OF REQUEST (Check One) ADD NEW LOGON ID CHANGE LOGON ID ACCESS DELETE LOGON ID

(21) LOGON ID (22) APPLICATION (23) ACCESS GROUP (24) ACCOUNT NUMBER

SECUREID REMOTE ACCESS complete as defined by L.A. County mgnt., e mail address is required, see box #5

(25) BILLING ACCOUNT NUMBER for SecureID Token: _____ (26) DEVICE TYPE: KEY FOB

VPN

SECURITY STATEMENT
Before connecting to the County network you must install anti-virus software, and stay up-to-date with definitions, Microsoft patches (critical and security) and service packs. A Firewall, either a hardware firewall or personal firewall software, is required for those using broadband Internet access (DSL, ISDN, cable modem, etc.). You agree not to share your logon id, password and SecureID passcode with others.

WIRELESS ACCESS Check the box if you are requesting wireless access. APPLICATION: _____

SIGNATURES each signature entry must be completed in full.
Your signature indicates that you have read and will comply with the above security statement.

(27) CUSTOMER'S SIGNATURE: *Sample D. Neverwrong*

(28) COUNTY DEPARTMENT MANAGER'S SIGNATURE *Susan B. Neheaven* (29) PHONE # 213-201-2001 (30) PRINT COUNTY DEPARTMENT MANAGER'S NAME SUSAN B. NEHEAVEN (31) DATE 7/15/2010

(32) ISD/APPLICATION COORDINATOR'S SIGNATURE (33) PHONE # 213-351-1335 (34) PRINT ISD/APPLICATION COORDINATOR'S NAME JOYCE A. FANTROY (35) DATE

NOTE: If submitting a PDF, FAX or COPY, this section must be completed in order to process the request.

PDF FAX COPY

AUTHORIZED MANAGER NAME AUTHORIZED MANAGER SIGNATURE:

NAME (Print) JOYCE FANTROY SIGNATURE: _____

My signature above, stipulates that my department has setup a process to maintain the original form on file for a period of 7 years, and will make the original form available within 72 hours, upon request from ISD or those acting on the behalf of ISD, internal or external Auditors.

WARNING: FAILURE TO FULLY COMPLETE & SIGN THIS FORM WILL CAUSE A DELAY IN PROCESSING.

SUBMIT TO: COUNTY OF LOS ANGELES/DMH/INFORMATION SECURITY-SYSTEMS ACCESS UNIT
695 SOUTH VERMONT AVENUE, 8TH FLOOR, LOS ANGELES, CA 90005

Revised: March 2010

Downey Data Center Registration, Contractor

- Provides a securID card. Initial authentication to permit end-users through the County's Firewall
- Form must be signed by both the data entry staff (Field 27) and the authorized manager/designee (Field 28).

•Please Do Not sign (Field 32)

Agreement For Acceptable Use and Confidentiality of...(AUP)

AUP

•User acknowledgement of confidentiality and violation penalties.

SAMPLE page (page 2) demonstrates that both the data enter staff (user) and authorized manager or designee signature are required.

36 108 144 180 216 252 288 324 360 396 432 468 540

**COUNTY OF LOS ANGELES
AGREEMENT FOR ACCEPTABLE USE AND
CONFIDENTIALITY OF
COUNTY INFORMATION TECHNOLOGY ASSETS,
COMPUTERS, NETWORKS, SYSTEMS AND DATA**

As a Los Angeles County employee, consultant, vendor or other authorized user of County Information Technology (IT) assets including computers, networks, systems and data, I understand that I accept a portion of user. I will use County IT assets for County authorized approved business purposes only and maintain the confidentiality of County's business and County's private data. As a user of County's IT assets, I agree as follows:

- Computer access:** I am aware of California Penal Code 502(c) - Computerized Computer Data Access and Fraud Act (hereinafter "CPD 502(c)"). I will immediately report any suspected computer misuse or abuse to my Manager(s).
- Security access controls:** I will not attempt to bypass any security measures or systems which have been implemented to control or restrict access to computers, networks, systems or data. I will not share my computer identification codes (log-in ID, computer access codes, account info, ID's, etc.) or passwords.
- Approved business purposes:** I will use the County's Information Technology (IT) assets including computers, networks, systems and data for County authorized approved business purposes only.
- Confidentiality:** I will not access or disclose any County program code, data, information or documentation in any individual or aggregate unless specifically authorized to do so by the assigned information owner.
- Computer virus and malware code:** I will not intentionally introduce any computer virus, worm or malware code into any County computer, network, system or data. I will not disable or delete computer virus detection and control software on County computers, systems and other computing devices I am responsible for.
- Offensive materials:** I will not access or send any offensive materials, e.g., sexually explicit, racial, hateful or inciteful or use or attempt to use County e-mail, local or managed local or wide area networks, including the public Internet and other electronic mail systems, unless it is in the performance of my assigned job duties, e.g., law enforcement. I will report to my supervisor any offensive materials observed by me on or in any County system.
- Public business:** I understand that the Public business is unclassified and contains many items that may be considered offensive to both user and manager. I will use County business services for approved County business purposes only, e.g., as a research tool or for electronic communications. I understand that the County's business services may be filtered but in any use of them I may be required to offensive materials. I agree to hold the County harmless should the materials be required in such offensive materials. I understand that any business services may be logged, are public record, and are subject to audit and review by authorized individuals.
- Electronic mail and other electronic data:** I understand that County electronic mail (e-mail) and data, in either electronic or other form, are a public record and subject to audit and review by authorized individuals. I will comply with County e-mail use policy and use proper business etiquette when communicating via e-mail system.
- Copyrighted materials:** I will not copy any licensed software or documentation except as provided by the license agreement.

10. **Disciplinary action for non-compliance:** I understand that any non-compliance with any portion of this Agreement may result in disciplinary action including any suspension, discharge, denial of services, cancellation of business or both civil and criminal penalties.

**CALIFORNIA PENAL CODE 502(c) -
"COMPREHENSIVE COMPUTER DATA ACCESS AND FRAUD ACT"**

Below is a version of the "Comprehensive Computer Data Access and Fraud Act" as it appears specifically in this Agreement. California Penal Code 502(c) is incorporated in its entirety into this Agreement by reference and all provisions of Penal Code 502(c) apply. For a complete copy, consult the Confidentiality website www.lga.ca.gov/

502(c) Any person who commits any of the following acts is guilty of a public offense:

- (1) Knowingly accesses and without permission alters, damages, deletes, destroys, or otherwise uses any data, computer, computer system, or computer network, or data or data (A) developed or owned, any software or hardware or device, or (B) knowingly caused or allowed another person, program, or data.
- (2) Knowingly accesses and without permission alters, copies or makes use of any data from a computer, computer system or computer network, or data or data (A) developed or owned, or (B) knowingly accesses and without permission alters, copies or makes use of any data from a computer, computer system, or computer network.
- (3) Knowingly and without permission uses or causes the disclosure of computer services.
- (4) Knowingly accesses and without permission alters, damages, deletes, or destroys any data, computer software or computer program which is critical to the national or state security, computer system, or computer network.
- (5) Knowingly and without permission disrupts or causes the disruption of computer services or data or causes the denial of computer services to an authorized user of a computer, computer system, or computer network.
- (6) Knowingly and without permission provides or causes to provide a means of accessing a computer, computer system or computer network in a violation of this section.
- (7) Knowingly and without permission accesses or causes to be accessed any computer, computer system, or computer network.
- (8) Knowingly introduces any computer contamination into any computer, computer system, or computer network.

I HAVE READ AND UNDERSTAND THE ABOVE AGREEMENT.


SAMPLE MEMBERWORKS	<i>Susan M. McWhorter</i>	7/15/2010
Employee's Name	Employee's Signature	Date
SUSAN M. McWHERTER	<i>Susan M. McWhorter</i>	7/16/2010
Manager's Name	Manager's Signature	Date

Form #3
Data Entry Staff

Data entry staff (user) and authorized manager or designee must sign this form.

Confidentiality Oath

36 72 108 144 180 216 252 288 324 360 396 468 504



COUNTY OF LOS ANGELES - DEPARTMENT OF MENDEL HEALTH
CIO BUREAU Information Security Systems Access Unit

CONFIDENTIALITY OATH

The intent of this Confidentiality Form is to ensure that all County, Contractor, Pharmacy, Non-Governmental Agency (NSA), and Fee-For-Service (FFS) Network Provider employees are aware of their responsibilities and accountability to protect the confidentiality of clients' sensitive information viewed, maintained and/or accessed by the IS on-line systems.

Further, the Department's Medi-Cal and MEEDS access policy has been established in accordance with Federal and State laws governing confidentiality.

Wellman and Institutions (W&I) Code, Section 14100.2, cites the information to be regarded confidential. This information includes applicant/beneficiary names, addresses, services provided, social and economic conditions or circumstances, agency evaluation of personal information and medical data. (See also 22 California Code of Regulations (C.C.R.) Sections 50111 and 51009.)

The Medi-Cal Eligibility Manual, Section 2-H, titled "Confidentiality of Medi-Cal Case Records," referring to Section 14100.2, a, b, f and h, W&I Code, provides in part that:

"(a) All types of information, whether written or oral concerning a person made or kept by any public office or agency in connection with the administration of any provision of this chapter, shall be confidential and shall not be open to examination other than for purposes directly connected with administration of the Medi-Cal program."

"(b) Except as provided in this section and to the extent permitted by Federal Law or regulation, all information about applicant and recipients as provided for in subdivision (a) to be confidential includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation or personal information and medical data, including diagnosis and past history of disease or disability."

"(c) Requires agents of the State to abide by rules and regulations governing the custody, use and preservation of all records pertaining to administration of the Medi-Cal program."

"(k) States "any person who knowingly releases or possesses confidential information concerning persons who have applied for or who have been granted any form of Medi-Cal benefits, for which State or Federal funds are made available in violation of this section's penalty of a misdemeanor."

Please read the agreement and take due time to consider it prior to signing.

I understand County, Contractor, Pharmacy, NSA, and FFS employees are prohibited from sharing their unique Logon ID and password with co-workers or other agencies.

Further, I understand County, Contractor, Pharmacy, NSA, and FFS employees are prohibited from obtaining, making or using confidential client information from case records or computer records for purposes not specifically related to the administration of services and authorized by the state Wellman and Institutions Code (Section 14100.2).

Further, I understand violation of confidentiality of records or of these policies, which are made for protection of confidentiality, may cause:

1. A civil action under the provision of the Wellman and Institutions Code Section 3330 or of Chapter 3 (commencing with Section 4330) of Part 1 of Division 4, for the greater of the following amount:
 - 1.) Ten thousand Dollars (\$10,000)
 - 2.) Three times the amount of actual damage, if any, sustained by the plaintiff.
2. Disciplinary action including suspension or termination of employment.

Further, I understand that the County will not provide legal protection if violations of these policies or procedures occur.

I hereby certify that I have read this form and the Department of Mendel Health Policy on Security and Integrity of Management Information System Data. I have knowledge of the requirements of state and federal confidentiality laws and will comply with its provisions.

I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions Code, Section 5326, et seq.

User's Name: CHILD SHOWWHITE Child Showwhite
Print Signature

Employee #: _____ Phone # (213) 200-2000 Ext. _____

Pharmacy, FFS, NSA Legal Entity Name: _____
 Provider #: 1234A Provider Name: PLENTY Mendel Health Services

Address: 2345 Happy Street / Clarey Blossom / 90021
City State Zip

Service Area: 5 Date: 3/14/2007

CIOB USE ONLY
 Approved By: _____ Date: _____
MSIS CIOB BUREAU

Form #4-07 - Confidentiality Oath (3/14/07)

KEEP THIS FORM ON FILE AT YOUR FACILITY

Form #4
Data Entry Staff
Maintain By Provider

Data Entry staff (User) must agree to established measures to safeguard sensitive and confidential data (PHI).

Provider must maintain this form in an office file and must be made available during audits and/or investigations.

Rendering Provider

Service Delivery Provider

- ***The Rendering Provider Form must be completed for all clinical staff members who are new or are not on the Integrated System. Rendering Provider must be associated at a provider location for claim submission purposes.***

- ***This form is to authorize association and is also to be used for clinical staff that have terminated services from a provider location or to update information, i.e., name change, license renewal, taxonomy, reporting unit effective date, or expiration dates.***

- ***When completing this form, please refer to the following guidelines:***
 - The original form must be completed in its entirety (if applicable), with the required signature. Fax, photocopy and/or e-mail forms are not acceptable.
 - All information must be current upon submission of this form.
 - Be sure all fields are completed accurately and appropriately to avoid delay in the processing of a request.
 - Forms, instructions, taxonomy codes (discipline codes), etc are posted on the Integrated Systems website at: http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

Rendering Provider

Service Delivery Provider

➤ Required Form

Required

- Rendering Provider Form

- Critical Information

Rendering Provider Form Instructions

•Taxonomy Codes and Description

- Authorized signer

•No “on behalf of” signatures

Microsoft PowerPoint - [PPP IS Summary]

template - Windows Internet Explorer

http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

File Edit View Favorites Tools Help

template

IS HOME DIRECTLY OPERATED CLINICS OUTPATIENT FEE-FOR-SERVICE CONTRACT PROVIDERS

Working in the IS ← → IS Forms

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[IS Forms](#)

[Clinical Forms](#)

[Co-Occurring Disorders Forms](#)

[Getting Help with the IS](#)

[Links](#)

[EDI / Secure File Transfer](#)

Want to order Forms from the DMH Warehouse? 213-738-4769

These forms are for Contract Providers
~ [Face Sheets/Billing Forms](#) ~

[Procedures for Forms](#)

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 - [Applications Access Form Instructions](#) rev. 6/06
 - [Applications Access Form](#) rev. 6/06 **SAMPLE**
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 - [IS Connection Options](#)
 - [SecurID Renewal Non County and AUP](#) and [Sample Form and Sample AUP](#)
 - [Request for Replacement of Lost PIN](#)
 - [Request to Change Funding Source on COS](#)

Link to Rendering Provider Forms:
http://dmh.lacounty.gov/hipaa/cp_ISForms.htm

Required forms, instructions, discipline codes, and other helpful information are listed under Service Deliver Staff

Sample

Internet 100%

Start Sent Item... PPP IS Su... Document... template... Adobe Acr... 4:25 PM

Rendering Provider Sample Form

Missing information will delay processing

Authorized Manager or designee signature is required

•No "on behalf of" signatures

N G A S A M P L E
RENDERING PROVIDER FORM

Mail to: Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
885 South Vermont Avenue
Los Angeles, CA 90005

Request Type

Submit Date: 04/11/07 New Update Terminate Name Change

General Information

Last Name: PEACEMAKER
First Name: NOEL
Middle Initial: S
DOB: 02/02
Language Code: 01

DMH/NGA Staff Code: H M H 0 2 1 3
FFS Ind Prov No: _____
SSN (Last 4 only): 0202
Language Code: 01

Select DMH Classcode:
 DMH
 DHS
 Non-Governmental Agency (DMH Contracted)
U.E. #: UC14
U.E. Name: HAVEN MH ASSOC.
 FFS Individual FFS Group FFS Org
Tax Payer ID (FFS only): _____

Contact & Assigned Location Information

Contact name: JANE NEWBERRY Contact Email: newberry@sample.net
Contact phone no: (211) 256-0123 Contact Fax No: (211) 256-1430

Add this rendering provider to the service location indicated below (please use form MH229 for additional locations)
 Delete this rendering provider to the service location indicated below Delete this rendering provider in ALL service locations within the legal entity indicated below.

DMH/NGA Prov No./Repl Unit: 7192A FFS Group/Org Prov No: _____
(Please enter the provider no. associated to the above taxpayer ID)

Effective Date: 04/11/07 Termination Date: _____ Locum Tenure: _____ Intern: _____

Name of Organization: HAVEN MENTAL HEALTH ASSOC. Service Area: _____ MHSA: _____
Address: 4231 NEW ATTITUDE BLVD City: RAGE TOWN Zip: 02346

Taxonomy and License Information (Required if request type is NEW)

Description: PHYSICIAN PSYCHIARTY Taxonomy: 2084P0800X
Professional License #: 01023891 Effective Date: 010107 Expiration Date: 010110
Description: _____ Taxonomy: _____
Professional License #: _____ Effective Date: _____ Expiration Date: _____
DCA License #: 010110 Expiration Date: 010110
Medicare Prov No. (DMH checks appropriate) _____ PPH Medicare No. (DMH checks appropriate only) _____ Expiration Date: _____
NPI: 1236702851 NPI Effective Date: 040207

Authorized Manager/Designee Signature: SIGNATURE REQUIRED Print Name: BEGONE JANUARY Date: 4/11/07

DMH USE ONLY

Rendering Provider ID No: _____ Ticket #: _____
Date Processed: _____ Processed by: _____

Revised: 3/14/2007 MH-229

Rendering Provider Form is required to allow Providers to submit claims for client's services.

Rendering Provider Form

➤ Submission Method

1. Hard copy — fillable form posted at http://www.lacounty.gov/hipaa/cp_ISForms.htm
2. Automation — online completion and submission
 - Submit “Individual Authorized to Sign CIOB Form”
 - Provider sent automation link and instructions
 - Benefits
 - “Go Green” - Save paper, ink, postal stamps, etc
 - Receipt confirmation
 - Timely processing and notification
 - Minimal incorrect form submission. Form designed according to Request Type.



Getting Help

- Contact CIOB/Help Desk at 213-351-1335 to reach a member of the Systems Access Unit team.