

Alta California Regional Center eBilling & EFT Enrollment Application

Instructions

Please read packet in its entirety. Pages 5 and 6 are for your records. Administrators must determine security levels for authorized users. Security levels are:

**Billing history-view only
Payment history-view only
Electronic Billing (Invoicing)-Update only**

Changes in users must be reported to ACRC immediately in writing. A new enrollment packet must be completed to delete, change, or add users.

Mail the completed packet to:

Alta California Regional Center
Accounting Department
2135 Butano Drive
Sacramento, CA 95825

For information on eBilling or to download the eBilling User Manual, please visit our website at:

www.altaregional.org

Questions? Email us at:

pos@altaregional.org

SERVICE PROVIDER PROFILE

Please complete a separate enrollment packet for each Service Provider number

Service Provider Name Service Provider Number Today's Date

Mailing Address Telephone Number

Service Address-If different from mailing address

E-mail Address

To be completed by Regional Center staff

Service Code Sub-Code Full Month Y/N Att Req'd Y/N

Service Code Sub-Code Full Month Y/N Att Req'd Y/N

Service Code Sub-Code Full Month Y/N Att Req'd Y/N

Service Code Sub-Code Full Month Y/N Att Req'd Y/N

Authorized User Security Info

Service Provider Name on File

Service Provider Number

Today's Date

USER PROFILE INFO

Your user name is the first initial of your first name and your full last name. Password must contain a minimum of 6 alpha/numeric characters.

Primary User Full Name:

E-mail Address:

Password:

User Access-Circle all that apply

Billing History

Payment History

Invoice & Submit

Additional User Full Name:

E-mail Address:

Password:

User Access-Circle all that apply

Billing History

Payment History

Invoice & Submit

Additional User Full Name:

E-mail Address:

Password:

User Access-Circle all that apply

Billing History

Payment History

Invoice & Submit

SERVICE PROVIDER AGREEMENT AND CERTIFICATION

I have read the attached Electronic Billing Agreement form and certify the information I have provided in this enrollment packet is true and correct. I agree to notify the Regional Center of changes to my Service Provider profile, user information and/or EFT changes by submitting a revised enrollment packet.

Authorized Representative Signature

Date

Print Name

Title

Telephone Number

E-mail Address

For Regional Center Use Only

Reviewed and Approved By

Set Up Complete

Date

Set Up Date

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

Service Provider Profile

Service Provider Name Service Provider Number for this profile Service Code

Mailing Address City State Zip Code

EFT Remittance Advice Contact Name and Email Address

Telephone Number Social Security or Employer Identification (EIN) Number

ACCOUNT INFORMATION:

Bank Name Service Provider name as it appears on bank account

Bank Routing Number (obtain from bank) Account Number

Account Type (Checking or Savings) Starting date (30 days from today's date to allow for prenote)

I hereby authorize Alta California Regional Center to electronically transmit payment for services in the bank account listed above. I have attached a voided check or other documentation from my bank for the account specified above. This authorization is to remain in force until the Regional Center has received written request to terminate or change EFT from an authorized representative.

I understand that payments are posted TWO BUSINESS DAYS after payment date. To see a schedule of vendor payment dates, please visit us at www.altaregional.org. All Remittance Advice Forms will be emailed to the address you provide.

I will inform the Regional Center, in writing, of changes to my bank account, address, and/or email address. I understand that significant delays in payment may occur if I do not report bank account changes to the Regional Center and hold harmless the Regional Center for any bank fees I incur as a result of failure to notify the Regional Center of such changes.

A minimum of 30 days from the receipt of this application is required to process your EFT request. EFT payments will include payments for all vendor numbers going to the same bank account.

Authorized Representative (Print Name) Signature Date

Approved at Regional Center by Date

Please attach a voided check or other documentation from your bank to this application and mail to:

Alta California Regional Center
Accounting Department
2135 Butano Drive
Sacramento, CA 95825

REGIONAL CENTER SERVICE PROVIDER ELECTRONIC BILLING AGREEMENT FORM**1. CLAIMS ACCEPTANCE AND PROCESSING**

The regional center agrees to accept from the enrolled Provider electronic invoices. The Provider hereby acknowledges that he or she has received and read and understands and agrees to abide by the EB provider manual and its contents, and agrees to read and comply with all EB provider manual updates and provider bulletins relating to electronic billing.

2. CLAIMS CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center consumers have been provided to the consumers by the Provider. The services were, to the best of Provider's knowledge, provided in accordance with the consumer's written Individual Program Plan. The Provider shall certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of five years from the date of final payment for the State fiscal year in which services were rendered a printed representation of all records which are necessary to disclose fully the extent of services furnished to the consumer. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I certify that the consumer(s) submitted through the electronic process were provided the services as authorized for the stated periods, and that no additional charges were made to other parties. These claims are submitted under penalty of perjury in accordance with the Medi-Cal program Provider Agreement Claim Certification.

3. VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

The Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all invoice information for payment. The Provider shall also assume personal responsibility for verification of submitted invoices with source documents. The Provider agrees that no invoice shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failures to make, maintain, or produce source documents shall be cause for immediate termination of electronic billing privileges.

4. CHANGE IN ELECTRONIC BILLING STATUS

The Provider and the Regional Center agree that any changes in Provider status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5. PROVIDER REVIEWS

The Provider agrees that agents of the Regional Center, the Department of Developmental Services, the Department of Health Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of invoices submitted electronically.

6. EFFECTIVE DATE

This agreement shall become effective upon approval of the Regional Center.

7. TERMINATION

The Department, Regional Center or Provider may terminate this agreement with or without cause by giving seven days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department or Regional Center. The Department or Regional Center may, however, terminate this agreement immediately upon determination that the Provider has failed or refused to produce or retain source documents in accordance with federal and state laws or this agreement or has violated other provisions of the provider agreement.

REGIONAL CENTER SERVICE PROVIDER ELECTRONIC BILLING AGREEMENT FORM

8. PROVIDER TO HOLD REGIONAL CENTER AND STATE OF CALIFORNIA HARMLESS

The provider agrees to hold the Regional Center and the State of California harmless for any and all failures performed by billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The provider agrees that the provider is assuming any and all risks that accompany electronic billing and that the provider is not relying upon the evaluation, if any, that the State of California or Regional Center has made of the electronic billing system or software the provider is using.

9. CONFIDENTIALITY OF RECORD

The Provider agrees to provide adequate precautions to protect the confidentiality of Consumer information in accordance with Welfare and Institutions Code section 4514.