MULTIPLE BILLING OVERRIDE CERTIFICATION

COUNTY/DIRECT PROVIDER: _____

CLIENT NAME: _____

CLAIM FOR MONTH/YEAR: _____ **FISCAL YEAR:** _____

Please complete this certification form for multiple services provided to a client for the same day.

SERVICE FACILITY/ LOCATION NPI	CLAIM SUBMITTER'S IDENTIFIER	LINE ITEM CONTROL NO. OR LINE ITEM SEQUENCE NO.	SERVICE DATE	UNITS BILLED	PROCEDURE CODE AND MODIFIER	OVERRIDE REASON**

***OVERRIDE REASON:**

1) The client could not receive all necessary services at one time. The client record clearly documents the date and time of day each visit was made and that the return visit was not a hardship on the client.

2) Crisis visit. Services are documented in client record.

3) Collateral services. Services are documented in client record.

I hereby certify that I am authorized to represent the county/DP. I recognize that the services specified above have been identified by the automated Short-Doyle/Medi-Cal claim processing system as those which are potentially

duplicative or otherwise inappropriate. I further certify that I have reviewed the client record specified above and have determined that the services billed were necessary and appropriate.

Signature: COUNTY/DIRECT PROVIDER REPRESENTATIVE	**Date**
TITLE	

RETAIN THE ORIGINAL CERTIFICATION IN THE CLIENT FILE ALONG WITH A COPY OF THE CLAIM. THIS DOCUMENT MUST BE PRODUCED ON DEMAND FOR AUDIT OR SITE VISIT BY ADP

DRAFT

COMPLETION INSTRUCTIONS FOR MULTIPLE BILLING OVERRIDE CERTIFICATION 7700

GENERAL

The ADP Multiple Billing Override Certification form is used by a Drug/Medi-Cal Provider to certify that an additional, second unit of service for the same client was submitted for the same service date. ADP 7700 documents that the additional service was medically necessary and was not a hardship for the client's return.

* Do not complete or send this form to ADP unless the specified claims require pre-approval for Delay Reason Codes 4, 11 and 8.

* The ADP 7700 must be signed by a person authorized to represent the county or provider to certify that the client record was reviewed, that the multiple service claim was valid per Section 51490.1 of Title 22.

* The ADP 7700 shall be prepared and retained in the beneficiary's patient record to be produced for monitoring and/or auditing purposes.

HEADING INSTRUCTIONS

a. COUNTY/DIRECT PROVIDER: if submitter is a county, enter the county name; if submitter is a direct provider, enter the direct provider name.

b. CLIENT NAME: enter the client's name for the claim.

c. CLAIM FOR MONTH/YEAR: enter the month and year of the claim.

d. FISCAL YEAR: enter the fiscal year for the claim.

COLUMN INSTRUCTIONS

a. SERVICE FACILITY/PROVIDER NPI CODE: enter the NPI code for the service facility and/or provider.

b. CLAIM SUBMISSION ID: enter the ID number for the claim.

c. SERVICE CONTROL LINE ID: enter the service control line ID number.

d. SERVICE DATE: enter the date the service was performed.

e. UNITS BILLED: enter the number of units being billed for this service.

f. PROCEDURE CODE MODIFIER: procedures codes and modifiers can be found in Tables D and E of the ADP Companion Guide Appendix.

g. OVERRIDE REASON: enter one of the following reasons:

1) The client could not receive all necessary services at one time. The client record clearly documents the date and time of day each visit was made and that the return visit was not a hardship on the client.

2) Crisis visit. Services are documented in client record.

3) Collateral services. Services are documented in client record.

SIGNATURE BLOCK INSTRUCTIONS

a. SIGNATURE - only authorized county or direct provider representatives should sign.

b. TITLE: enter the title of the representative signing the form.

c. DATE: enter the date the form was signed by the authorized representative.

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