PROVIDER PORTAL
USER GUIDE

Google Chrome is the preferred browser of choice for this site

Table of Contents

INTRODUCTION

Welcome to the CenCal Health Website www.cencalhealth.org . The Website contains many interactive capabilities such as checking member eligibility, request pre-authorizations, claims billing and report capabilities.

This document contains step-by-step instructions on how to access CenCal Health's interactive portal for Providers, Administrators and Staff. Websites are not static documents they are updated and changed constantly to meet the needs of users, to improve functionality, and to meet nationally recognized standards and regulations in healthcare.

MEMBER ELIGIBILITY & IDENTIFICATION

CenCal Health does NOT determine eligibility and a member's eligibility with CenCal Health can change. Medi-Cal members receive a permanent plastic identification card called a Benefits Identification Card or "BIC" and a CenCal Health Insurance card.

GROUP PLAN IDENTIFICATION KEY
110 Santa Barbara Health Initiative (SBHI) Medi-Cal
1120 San Luis Obispo Health Initiative (SLOHI) Medi-Cal

These card must be used for identification purposes but does not provide proof of eligibility. These cards are issued only once and reissued only when information on the card has changed.

FOR PROVIDERS

There are many ways to access our Provider Portal once you select 'Providers' icon.

POVIDER PORTAL (RESTRICTED)

New User Account Access

This area is "restricted" to authorized users only. New In-Network contracted providers will receive a username and password after they have contacted CenCal Health. For questions on this portal or account access, contact the Web Master at webmaster@cencalhealth.org.

Please appoint a 'Physician/Administrator' for your office as this staff member will manage all user access to the portal and will be responsible for setting your office staff accounts through this portal.

CenCal Health encourages all individual user accounts to be secure and not used by multiple users. CenCal Health will not be held responsible for any erroneous use of a provider user account.

User Account Information Requirements:
- Provider/Organizations Name
- Tax Identification Number
- National Provider Identifier (NPI)
- Physician/Administrator E-mail address (preferred, organizational email address)
- Point of Contact

Portal Log In

Once you click on the [Provider Login] icon, you will see the following screen:

First Time Login:
All individual accounts are created by your 'Physician/Administrator' User within your practice. After your account is created, the individual User will login with their email address as their Username, and a temporary password will be provided. The system will prompt the user to create their own individual password.

Password Change Policy:
The system will prompt each User to change their password after 180 days of entry.

Password Entry Error or Password Assistance:
If you enter your information after (3) three invalid attempts, the system will lock your account. Your 'Physician/Administrator' can also 'Unlock' your account or provide assistance on creating new accounts.

Forgot your Password?
All Users can reset their password through the 'Forgot your password?' function and the system auto assign a temporary password for access.

Automatic Deactivation Policy:
CenCal Health will automatically deactivate all User accounts if no activity of the portal is utilized after 90days. It is still the responsibility of the Administrative User to deactivate accounts if staff no longer work for your practice.

User Screen Role Access:
All interactive features are listed along the left column of the page and are specific to each 'User Role' (i.e. if you submit claims you should see the 'Claims Entry'). Please contact your 'Physician/Administrator' within your organization if you need access to specific roles so you can have them added to your interactive tab.

Multi-User Access:
Users could have 'multi-user' access for more than one group (i.e. third party billers that have access to more than one IRS#). In this instance, the User will be able to toggle to each specific IRS# they are assigned to by clicking the IRS drop down box.

DATA FORMS OVERVIEW HOME PAGE

The screen above indicates all active forms available on the portal. Please contact your Physician/Administrator should you need access to any of the above screens. The details provided below contain step-by-step instructions on how to access CenCal Health's interactive portal.
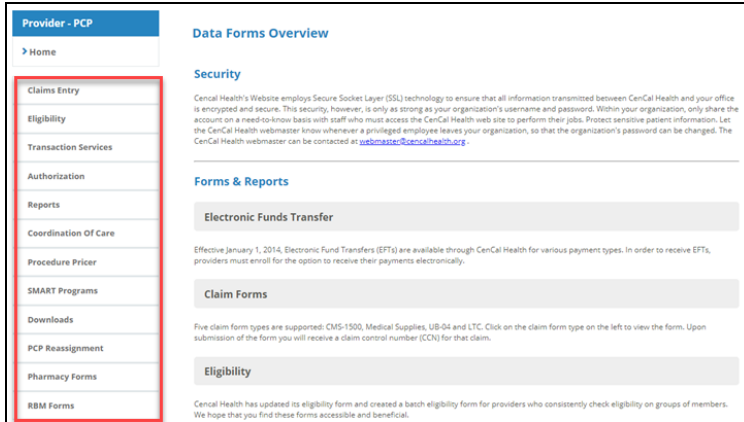
USER MANAGEMENT>User Accounts
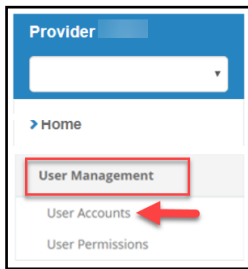
The User Management screen allows all Administrative Users to manage all user accounts within your group, create new user accounts, set roles, reset individual temporary passwords, and terminate accounts for those that no longer need access.

User Accounts

Allows the Admin User to view an alphabetized list of your staff's UserName by their organizational email address. To view a full list of Active and Inactive, click on the

Include Inactive Users box located in the top right corner as needed.

Edit: Allows the Admin User to make changes to your staffs name, activation status, and more remarks.

Password: Allows you to change the users password and create a temporary password

UnLock: Allows the Admin User to unlock the individual's password if they try and log into the portal three (3) times incorrectly. This does not change the password, unless you click on 'Reset Password'.

Access: This function will allow the Admin User to add/delete screen permissions to your staffs account. These screen permissions are specific to the Provider Portal screens (Eligibility, Auths, Reports, etc.).

Create New User

Click on 'Create New User' when you want to give portal permissions to a new staff member

Enter your staff members individual email address (this will become their individual UserName when logging into the portal) along with all other required fields.

The 'Department' and 'Remarks' field is free hand text boxes. The 'Job Role' drop down box will allow you to choose job roles with predefined permission sets for your staff (if you want to customize it, click on 'Other'), then click **CREATE** .

**Helpful Tip: If you enter the wrong 'Email' address, you will need to deactivate the account and create a new one with the correct email address.

This next screen will auto populate the details for this user and allow the Admin User to manage 'Edit' or add 'Permissions' to the new account.

Edit: Allows the Admin User to make changes the user's JobRole, Active Status, and End_Date the account.

JobRoles: This function will allow the Admin User to add/delete screen permissions to your staffs account. These screen permissions are specific to the Provider Portal screens (Eligibility, Auths, Reports, etc.).

Back to List: Takes you back to the original staff Application User Account list

If you need to give access to a separate user that has multiple accounts with other provider groups (e.i. a Biller that bills for many different doctors), please contact our Webmaster at www.webmaster@cencalhealth.org or directly at (805) 562-1676 and they will assist with this user account.

Grant Portal Screen Roles/Permissions
Will allow the Admin User to create additional portal screen permissions to a user account.
All screen permissions will be listed in the top blue box.

Create/Reset User Password
On the main User Account page, search for your staff member and click 'Password'. This allows the Admin User to create, reset, or change the Users password and create a temporary password.

The screen will auto assign a temporary password for your user when creating or resetting a password. The Admin User can also create a different temporary password as long as it meets the specific minimum character criteria. After you click SET/RESET PASSWORD , the system will then send your staff member their temporary password, along with a confirmation email to the Admin User.

The account will then be placed in a temporary status and your user will need to log in with the assigned temporary password and create their own password.

The system will automatically create a temporary password for each user or the Admin User can create one.

UnLock User Account

If a user logs into the Provider Portal and it is entered incorrectly three (3) times, the system will automatically lock the user account, and they will need to contact their Administrator to 'UnLock' their account. The User can also create a new password for themselves through the 'Forgot your password?' function.

Deactivate Accounts

Go to the main 'Application Access List' and locate your staff name via the search tool and click 'Edit'.

Switch 'Active' drop down to 'N', enter an 'End_Date' and click 'Save'.
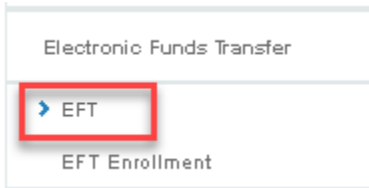

User Permissions

The screen below indicates 'Permissions' and the ability to 'Edit' all of your staff that are under the same group Tax ID#.

Edit: Allows the Admin User to edit that Users account details

Permissions: Allows the Admin User to change their individual screen permission access and/or to make them additional Admin Users.
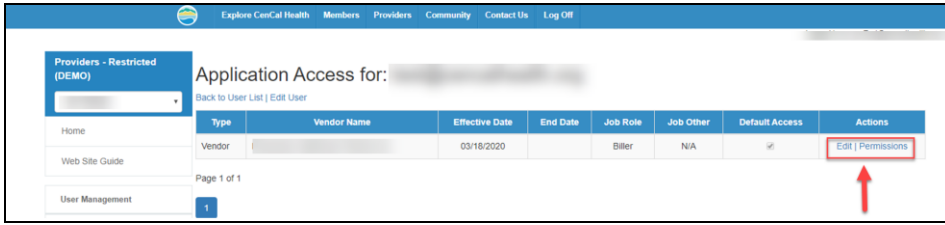
ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Fund Transfers (EFT) is a method of a weekly payment offered by CenCal Health to our participating contracted providers. EFT automatically credits all payments due for healthcare services performed directly to your savings or checking account. This payment method replaces issuing a paper check for various payment types

To enroll into Electronic Funds Transfer, please contact Provider Services at (805) 562-1676. If Financial Institution information changes, or you receive payment failure, or for general questions, please notify CenCal Health via email at eft@cencalhealth.org or contact our Finance Department at (805) 562-1081.For additional information go to www.cencalhealth.org/providers/claims and reference the 'Electronic Funds Transfer' tab.

Once enrolled specific staff assigned to this screen permission have the ability to view ![Active toggle] accounts and past deactivated accounts. Assigned provider staff have the ability to view more details via the ![Edit] icon.

The next screen allows the provider to edit the point of contact and email address via the ![pencil icon] icon. In addition the screen allows you to view the EFT enrollment date, Bank, Routing Number, Account Number, Account Type, Bank Enroll Date (DT), Bank Short Name, Account Holder (Provider Group Name), and Account Status.

In addition, this screen will indicate Payment Types, Bank Name associated to that payment type, a list of those how modified the account, and the modified date. If edits are made to this account, the CenCal Health Finance Department will be in direct connection with all point of contacts prior to approving the edits.

CLAIMS ENTRY

Claims Entry
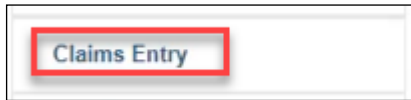
Claims Module Dashboard

There are two different types of claim forms that are supported on the Website: CMS-1500, and UB-04 Form.

Once you submit your claim you will receive a **Claim Control Number (CCN)**. Every CCN is a unique identifier for each claim submitted to CenCal Health. The CCN consists of the date the claim is received (e.g. 20050309), the provider type (e.g. 02 is medical), the claim type (e.g. 88 is a Medi-Medi crossover claim), and a sequence number. For website submitted claims, the claim type is 09.

Here is an example of a CCN once submitted to CenCal Health:

CCN
20211117029

The main dashboard allows you to search for a specific claim using any field on any combination of fields at

the top of your screen, and the list will sort based off of your search filter after you click the [🔍] icon. You can click the following icons to reset the dashboard, or export your filter to a downloadable CSV file.

RESET **EXPORT**
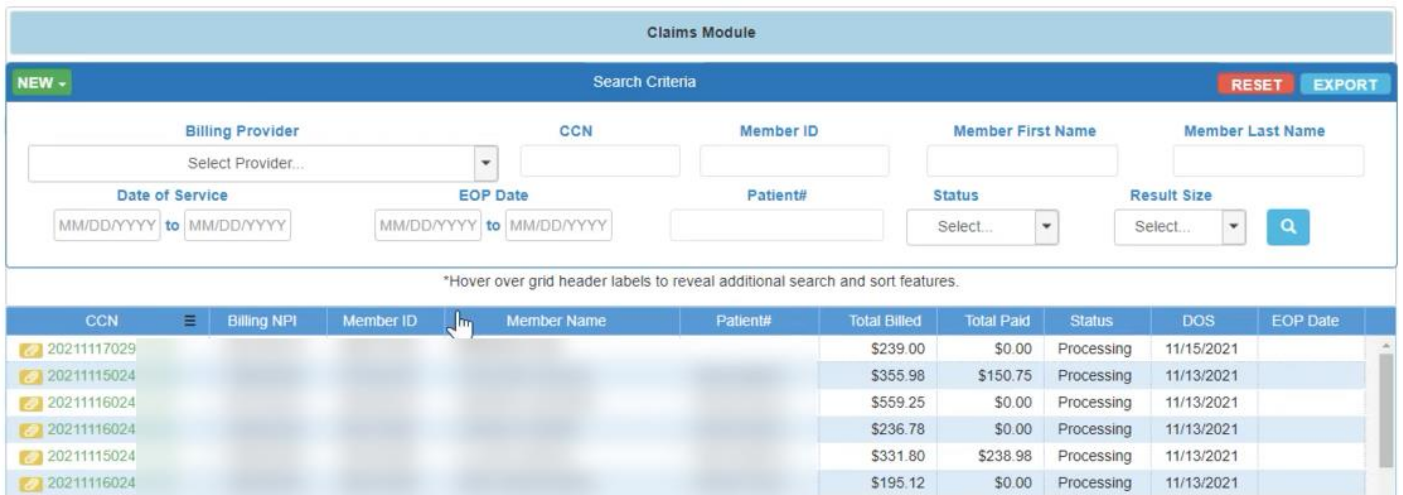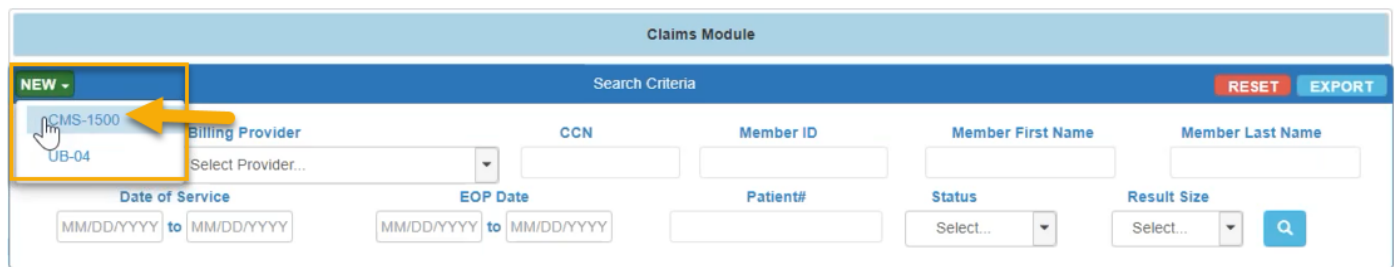
Claims Module									
NEW ▾		Search Criteria						RESET	EXPORT

Billing Provider	CCN	Member ID	Member First Name	Member Last Name
Select Provider... ▾				

Date of Service	EOP Date	Patient#	Status	Result Size	
MM/DD/YYYY to MM/DD/YYYY	MM/DD/YYYY to MM/DD/YYYY		Select... ▾	Select... ▾	🔍

*Hover over grid header labels to reveal additional search and sort features.

CCN	☰	Billing NPI	Member ID	Member Name	Patient#	Total Billed	Total Paid	Status	DOS	EOP Date
20211117029						$239.00	$0.00	Processing	11/15/2021	
20211115024						$355.98	$150.75	Processing	11/13/2021	
20211116024						$559.25	$0.00	Processing	11/13/2021	
20211116024						$236.78	$0.00	Processing	11/13/2021	
20211115024						$331.80	$238.98	Processing	11/13/2021	
20211116024						$195.12	$0.00	Processing	11/13/2021	

Submit a CMS-1500 Claim

Click the [NEW ▾] icon from the main dashboard to submit a CMS1500 claim form.

Claims Module					
NEW ▾		Search Criteria			RESET EXPORT
CMS-1500	Billing Provider	CCN	Member ID	Member First Name	Member Last Name
UB-04	Select Provider... ▾				
	Date of Service	EOP Date	Patient#	Status	Result Size
	MM/DD/YYYY to MM/DD/YYYY	MM/DD/YYYY to MM/DD/YYYY		Select... ▾	Select... ▾ 🔍

You will then be taken to Health Insuracnce Claim Form – Professional.

Health Insurance Claim Form - Professional

Member / Patient Information

Member No.*	Member Name*		DOB*	Gender	Relationship	MRN/Account No.
	First Name	Last Name			Self	

* Member ID and either DOB or First/Last Name are required

▼ Coverage Info (Most Recent)

Provider/Billing Information

Billing Provider NPI*
Select Provider...

Taxonomy

Referring Provider NPI	Name	Specialty	Service Facility NPI	Name	Specialty

Claim Information

ClaimType*	Auth No.	SOC	Chrg Amt	Anesthesia Start/Stop Time	Delay Reason	Patient No.
Select..		0.00	0.00	/		

Reserved For Local Use-Remarks

Diagnosis Codes:*

A	B	C	D	E	F
G	H	I	J	K	L

Line Items + Add COB/OHC ▾

#	Service Date(s)	POS	Emg	Proc	Modifiers 1	2	3	4	Diag Ptr*	Charge	Units	Fam Pln EPSDT	Auth No.	Rend NPI	Taxonomy
	NDC/UPN	Code	Quantity	UofM	PaidAmount		CapAmount		Status	Reason Codes					
1	to			Q						0.00					
					0.00		0.00								
2	to			Q						0.00					
					0.00		0.00								
3	to			Q						0.00					
					0.00		0.00								
4	to			Q						0.00					
					0.00		0.00								
5	to			Q						0.00					
					0.00		0.00								
6	to			Q						0.00					
					0.00		0.00								

Total Charges 0.00

To maneuver through the screen use your Tab key. Shift + Tab will allow you to move back one box. If you enter the data elements incorrectly the screen will populate with an error message in red.

Member/Patient Information: Please enter the Member ID# and either the Date of Birth (DOB) or the First/Last Name of the member. The Name and gender will auto populate.

Member / Patient Information

Member No.*	Member Name*		DOB*	Gender	Relationship	MRN/Account No.
					Self	

* Member ID and either DOB or First/Last Name are required

The Relationship drop down is used if you are billing for a newborn (up to the first 2 months of life) under the mother's Member ID#.

MRN/Account No. is available for your own internal account tracking.

Relationship
Self
Self
Child

Coverage Info (Most Recent) allows the user to view the members current member eligibility details and assigned Primary Care Provider (PCP) Group.

▼ Coverage Info (Most Recent)			
Health Plan	**Line Of Business**	**Effective Date**	**Term Date**
SLOHI	HA1200	11/1/2021	11/30/2021
PCP Name	**PCP NPI**	**PCP Phone**	**PCP Fax**

Provider/Billing Information allows the user to pull from a list of Billing Provider NPI#'s associated to the IRS#, enter Taxonomy, Referring Provider NPI, and Service Facility NPI. All areas in grey will populate once those details are entered.

Provider/Billing Information			
Billing Provider NPI*		**Taxonomy**	
Select Provider...			
Referring Provider NPI	**Name** **Specialty**	**Service Facility NPI**	**Name** **Specialty**

Claim Information allows the user to select from a Claim Type of Physician, Vision, Allied, or Medi-Medi. Please also add the approved authorization number to the 'Auth No.', Share of Cost (SOC), Anesthesia Start/Stop Time, Delay Resons (is used to report a reason for timely filing delay to avoid claims reduction within your payment), and Patient No. (is for the group to add their internal patient number for this encounter) field if applicable. The 'Reserved For Local Use-Remarks' box can be used to enter any additional information to help with processing the claim in addition to a corrected claim, newborn claim, or a mid-level provider NPI#.

The Charged Amount (Chrg Amt) will be greyed out and is calculated based off the 'Line Item' details.

Claim Information						
Claim Type*	**Auth No.**	**SOC**	**Chrg Amt**	**Anesthesia Start/Stop Time**	**Delay Reason**	**Patient No.**
Select..		0.00	0.00	/		
Reserved For Local Use-Remarks						

Diagnosis Codes:*

A	B	C	D	E	F
G	H	I	J	K	L

Diagnosis Codes are required and the user can manually enter the code, or click on the [🔍] icon to search from a list of codes. The code will then populate on the form once you click [Select].
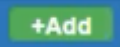
Search for a ICD Code ×

Enter: [ ] [Search]
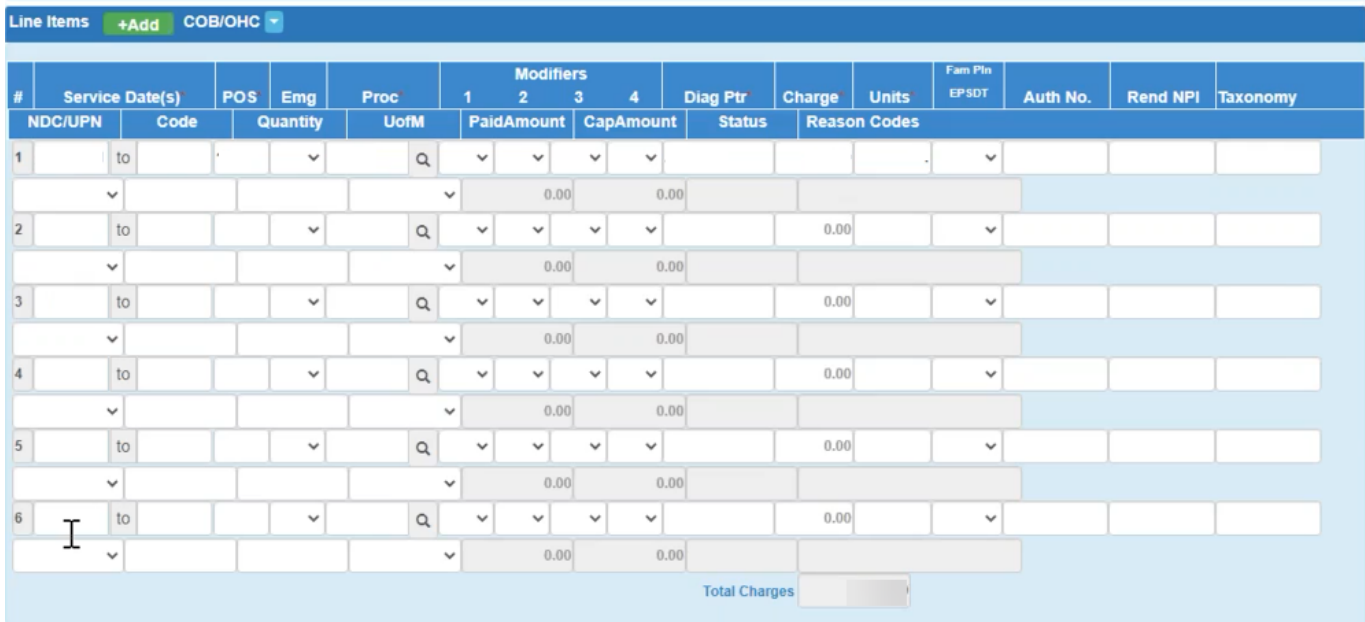
Code	Description
○ A000	Cholera due to Vibrio cholerae 01, biovar cholerae
○ A001	Cholera due to Vibrio cholerae 01, biovar eltor
○ A009	Cholera, unspecified
○ A0100	Typhoid fever, unspecified
○ A0101	Typhoid meningitis
○ A0102	Typhoid fever with heart involvement
○ A0103	Typhoid pneumonia
○ A0104	Typhoid arthritis
○ A0105	Typhoid osteomyelitis
○ A0109	Typhoid fever with other complications

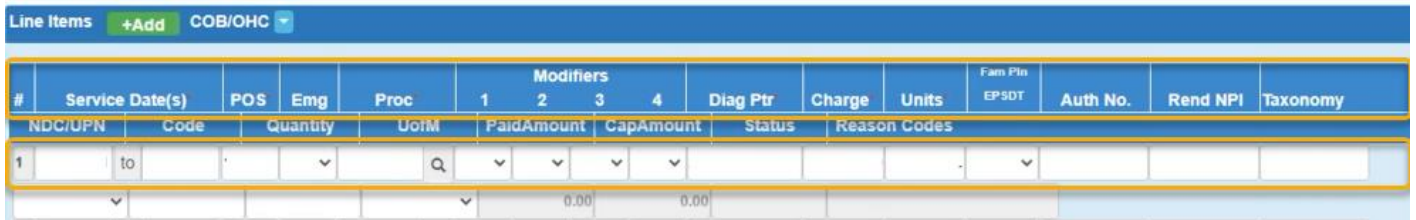Page 1 of 7275

[1] 2 3 4 5 6 7 8 9 10 ... » »»

[Select] [Cancel]

Line Items allows the user to enter 6 lines of service. To add more, click the ![+Add] icon to add 6 more line items to this claim for a total of 12.
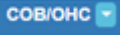
The first row allows you to enter the Service Date(s), Place of Service (POS), an Emergency claim 'Y' indicator, Procedure CPT code, Modifiers, Diagnosis Pointers (Diag Ptr) is required to be seporated with a ',' comma if you have more than one. Input the Charge amount (which will be calculated at the bottom of the form under Total Charges), Units, if this is for Family Planning Services, Auth No., Rendering Provider NPI#, and Taxonomy Code.

The second row allows you to enter the NDC/UPN, Code, Quantity, and Units of Measurement (UofM). The PaidAmount, and Cap Amount will auto populate on the screen.

If a member has Other Health Coverage (OHC), you can add those details by clicking the ![COB/OHC] icon and a third line in blue will populate for entry.

Click on the ![submit] submit icon to send the claim to CenCal Health for processing.

Once you have submitted your claim, the 3 icons will be available at the top right after submission. The green Add icon allows you to enter a new claim. The yellow paper clip icon allows you to add attachments.

You will also see that the 'Claim Created Successfully'.

Health Insurance Claim Form - Professional

Claim Created Successfully

You can also view the 'Status' of each line item by scrolling down to the Line Items Box, and view the current status of the claim at the line level shown here in this example with a Denied reason code for invalid/missing Rendering NPI#. In this case, the user can correct the claim, and click the save icon to save your corrections. The claim number will stay the same.

You may not use the Back button on your web browser to make changes. Instead, make the changes and click on the blue Submit button to save the changes.

Submit a UB-04 Claim

Click the icon from the main dashboard to submit a UB-04 claim form.

You will then be taken to Health Insuracnce Claim Form – Institutional.

Health Insurance Claim Form - Institutional

Member / Patient Information

Member No.*	Member Name*		DOB*	Gender	Relationship	MRN/Account No.
	First Name	Last Name			Self	

*Member ID and either DOB or First/Last Name are required

▼ Coverage Info (Most Recent)

Provider/Billing Information

Billing Provider*	Taxonomy	Admitting NPI	Name	Specialty
Select Provider...				

Attending NPI	Name	Specialty	Operating NPI	Name	Specialty

Claim Information

Claim Type*	Bill Type*	Admit Date	Admit Hr	Discharge Hr	Admit Type	SOC	Patient No.
Select..		mm/dd/yy				0.00	

Admit Source | Inpatient Status | Condition Codes:

Occurrence Codes:

Code	Date	Code	Date	Code	Date	Code	Date	Code	Date	Code	Date	Code	Date	Code	Date
	mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy

Value Codes:

Code	Amount	Code	Amount	Code	Amount	Code	Amount	Code	Amount	Code	Amount
	0.00		0.00		0.00		0.00		0.00		0.00

Claim (Additional)

Authorization No.	DRG Code	Admit Dx	Delay Reason	Remarks

Diagnosis Codes/POA Indicator:*

A		B		C		D		E		F	
G		H		I		J		K		L	
M		N		O		P		Q		R	

Principle Procedure:

Code	Date	Code	Date	Code	Date	Code	Date	Code	Date	Code	Date
	mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy

#	Service Date(s)*		Rev Code*	Proc*		Modifiers 1	2	3	4	Charge	Units*	Auth No.	
	NDC/UPN	Code	Quantity	UofM		PaidAmount	CapAmount		Status		Reason Codes		
1		to								0.00			
						0.00		0.00					
2		to								0.00			
						0.00		0.00					
3		to								0.00			
						0.00		0.00					
4		to								0.00			
						0.00		0.00					
5		to								0.00			
						0.00		0.00					

Member/Patient Information: Please enter the Member ID# and either the Date of Birth (DOB) or the First/Last Name of the member. The Name and gender will auto populate.

Member / Patient Information

Member No.*	Member Name*		DOB*	Gender	Relationship	MRN/Account No.
					Self	

*Member ID and either DOB or First/Last Name are required

The Relationship drop down is used if you are billing for a newborn (up to the first 2 months of life) under the mother's Member ID#.

MRN/Account No. is available for your own internal account tracking.

Coverage Info (Most Recent) allows the user to view the members current member eligibility details and assigned Primary Care Provider (PCP) Group.

Provider/Billing Information allows the user to pull from a list of Billing Provider NPI#'s associated to the IRS#, enter Taxonomy, Admitting NPI, Attending NPI, and Operating NPI. All areas in grey will populate once those details are entered.

Claim Information allows the user to select from a Claim Type (Physician, Inpatient, Outpatient, Medi-Medi, and LTC). Choose from a list of Bill Types, enter the Service From/Thru Dates, Admit Date, Admit HR, Discharge Hr, Admit Type (Emergency, Elective, Newborn, Trauma, and Information Not Available), SOC and Patient No. (used for the group to add their internal patient number for this encounter) field if applicable.

Choose from a list of Admit Source, Inpatient Status, Condition Code, and Value Codes.

Clam (Additional) enter Authorization No, DRG Code, Admit Dx, Delay Reasons (if applicable), and Remarks.

Diagnosis Codes are required and the user can manually enter the code, or click on the [Q] icon to search from a list of codes. The code will then populate on the form once you click [Select].

Line Items allows the user to enter 6 lines of service. To add more, click the [+Add] icon to add 6 more line items to this claim for a total of 12.

The first row allows you to enter the Service Date(s), Revenue Code, Procedure Code, Modifiers, Charge Amount, Units, Authorization No.

The second row allows you to enter the NDC/UPN, Code, Quantity, and Units of Measurement (UofM). The PaidAmount, and Cap Amount will auto populate on the screen.

If a member has Other Health Coverage (OHC), you can add those details by clicking the [COB/OHC ▼] icon and a third line in blue will populate for entry.

It can also be added to the header level by clicking on the COB/OHC dropdown arrow.

Click on the [H] submit icon to send the claim to CenCal Health for processing.

18

Once you have submitted your claim, the 3 icons will be available at the top right after submission. The green Add icon allows you to enter a new claim. The yellow paper clip icon allows you to add attachments.

You will also see that the 'Claim Created Successfully'.

You can also view the 'Status' of each line item by scrolling down to the Line Items Box, and view the current status of the claim at the line level shown here in this example with a Denied reason code for invalid/missing Rendering NPI#. In this case, the user can correct the claim, and click the save icon to save your corrections. The claim number will stay the same.

You may not use the Back button on your web browser to make changes. Instead, make the changes and click on the blue Submit button to save the changes.

Upload Attachments

Once you save the details within your claim, you have the ability to upload attachments for further review.

Click on the Add Attachment icon to upload your supporting documents.

Follow the steps to indicate the Category type (Initial, or Additional), and then click Choose File icon to upload documents from your file data source.

Once the document is chosen, the screen will indicate file name, and the UPLOAD ATTACHMENT icon button will appear once a file has been selected for upload. Click UPLOAD ATTACHMENT to save the document to the claim.

The document(s) will then be connected to your claim. Use the ➕ button to add additional documents.

All files will only be accessible for download for 30days from the created date, and will show as 'Not Available' on the list above once it hits the 30 day mark. CenCal Health staff will still have access to view internally.

When you are finished entering your claims, you may select the Back to Claim List option on the upper left side of the screen to return to the dashboard.

ELIGIBILITY

Check Eligibility

This system only looks within CenCal Health's member/subscriber database for the eligibility. CenCal Health does NOT determine eligibility and a member's eligibility with CenCal Health can change.

Check Eligibility/ Save as PDF/ Reset Form Fields

20

Required Filters

1. Enter the Member's nine (9) digit ID Number **or** Last four (4) numbers of Member's social security number (SSN)
2. Enter Date of Birth **or** Member's First Name/ Last Name
3. Enter Date of Service (DOS) current or past date in the format mm/dd/yyyy
4. Click [icon] 'Check Eligibility' icon

   ❖ Tip: Click the 'reset' [icon] icon to refresh your search

Primary Care Provider (PCP) Name (Phone) drop down indicates last (12) twelve months of eligibility as of the date of service entry.

If you have a non eligible member, you will see a red 'N' listed under 'Eligibility' and you can 'Check with DHS' directly by clicking on the orange box above.

Share of Cost (Soc)

A red 'Member is not eligibility' indicator will appear if a member is not eligible. The User can then check eligibility with 'DHC Check' `DHS Check` and/or clear the members share of cost through the 'SOC Trans' `SOC Trans` icon which is a direct link to DHCS login page to clear a members SOC.

Adding Member to batch from Eligibility Screen

After viewing a members individual eligibility, you may add the member to a Batch File via the
`+` icon. The member information will then auto populate to the file you want them added to by clicking the `Add Member` icom.

Add Member (90   tch: CVHC 2/27/2018 ▼

New Batch: Enter New Batch

Close   Add Member

Batch Eligibility

Eligibility

Check Eligibility

Batch Eligibility

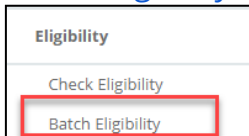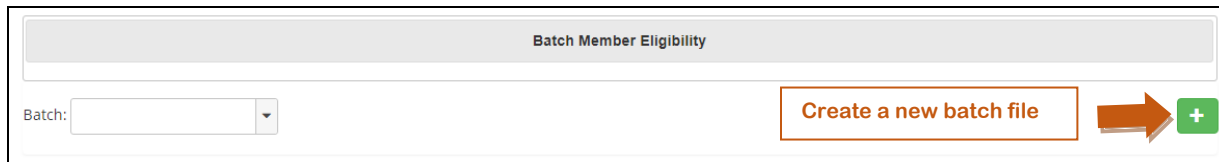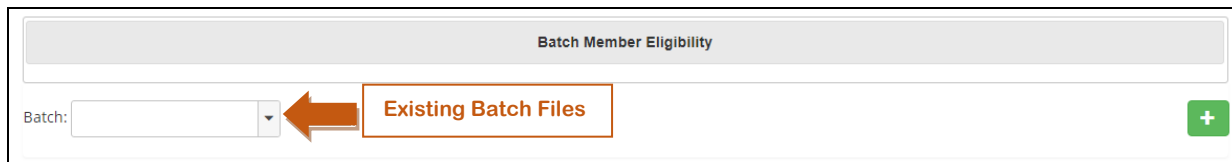Batch Eligibility is used to verify eligibility for several Members. All provider types have access to this function and is not limited to Primary Care Physicians (PCP). The purpose of this screen is to allow providers to create files of members that are seen in their office on a regular basis, and view their eligibility within one file (i.e.CCS Members, Other Health Coverage Members, etc.)

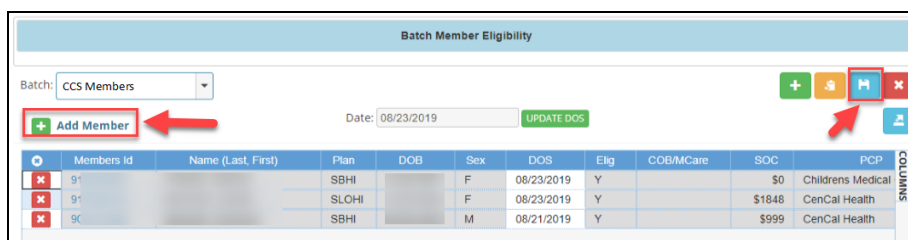To create a new batch, click the 'New Batch' `+` icon, and create your file name.

Batch Member Eligibility

Batch: [▼]   **Create a new batch file** ➡ `+`

To review an 'Existing Batch' click on the drop down box to locate the file.

Batch Member Eligibility

Batch: [▼] ⬅ **Existing Batch Files**   `+`

To add a member, click the green '+' `+` icon, and an additional row will be added.

Enter the Member ID, Name (Last, First), Date of Birth (DOB), and click the save `💾` icon. You will then see the eligibility status of the member you manually enter, and/or add from the eligibility screen.

Batch Member Eligibility

Batch: CCS Members ▼   `+` `🔒` `💾` `✕`

`+` Add Member   Date: 08/23/2019 UPDATE DOS   `⬆`

⊙	Members Id	Name (Last, First)	Plan	DOB	Sex	DOS	Elig	COB/MCare	SOC	PCP
✕	9		SBHI		F	08/23/2019	Y		$0	Childrens Medical
✕	9		SLOHI		F	08/23/2019	Y		$1848	CenCal Health
✕	9		SBHI		M	08/21/2019	Y		$999	CenCal Health

The member will then be added to the list and list their eligibility status.

To delete a member from the list, click on the red box ❌ icon, and then click save 💾.

Create New Batch File, Copy a Batch, Save, Delete

Export to CVS

Providers can create a new batch ➕, copy an existing batch to modify 🔶, or delete ❌ by clicking on the icons above. If you make changes to this screen, the Warning box will appear to save changes ✅, Do not save changes ⚠️, or cancel request ❌.

Warning
Would you like to save your changes?

TRANSACTION SERVICES
Medi-Reservation

Transaction Services
Medi-Reservation
Share of Cost

A two service per month limitation applies to all Limited Service Providers. Limited Service Providers consist of Audiologists, Acupuncturists, and Chiropractors. Services applied to the two services per month limitation do not require a Referral Authorization Form (RAF) from the member's PCP, but must be reserved through the Medi Reservation system below. A confirmation number will be given once the service is reserved. Please note: if a member needs additional audiology beyond the 2 service limit, additional authorization will be required. Members are restricted to a combined total of 2 acupuncture and chiropractic visits per month and will not be granted authorization for additional services beyond this limit.

Reset Form **CenCal Health MEDI Reservations**

Type   Reservation ▾

Prov#   [   ]

Member ID   [   ]

Service Date [   ]

Procedure   [   ]

Submit Form   Reset Form

The procedure code on the reservation must match the procedure code on the claim. If the code billed is different than the code reserved, reverse the reservation and resubmit it with the correct code. This can be done by selecting 'Reversal' in the drop down.

Note: Providers should not reserve a Medi-Service unless certain that the service will be rendered. Providers who do not provide a Medi-Service that has been reserved must reverse the reservation to allow the recipient to obtain another service.

Share of Cost
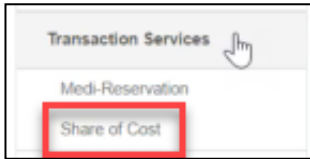
A Share of Cost also known as SOC is a monthly dollar amount which a patient is required to pay before they become eligible with Medi-Cal and CenCal Health. We are not involved with determining this dollar amount, it is based on criteria supplied by the member to their Eligibility Worker at Department of Social Services. SOC patients are considered 'cash pay' patients until the SOC is met

every month and members will need to pay prior to becoming eligible for benefits. If a provider collects a payment prior to rendering service, it is their responsibility to clear the members share of cost (SOC) directly with DHCS.

It is very important to clear the SOC as soon as they are seen. In some circumstances, members will see other specialists in the same day or try and pick up their prescriptions, please print this receipt for the member for proof of payment.
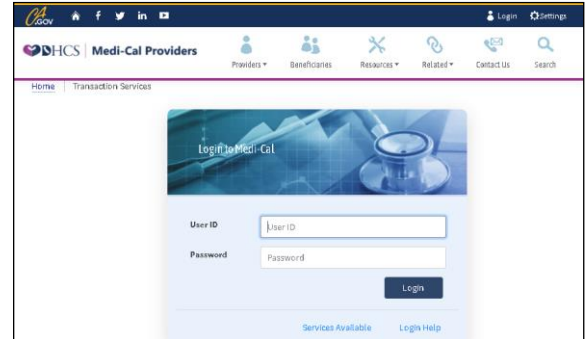
AUTHORIZATION
Add/view Authorizations
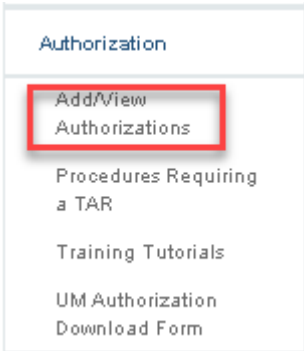
There are four (4) Authorization types that providers can submit online such as the Medical TAR (50-1), Request for Extension of Stay in Hospital (18-1), LTC Authorization Form (20-1), and the PCP Referral Authorization Form (RAF).

The main home screen allows a provider to see a list of authorization types, a hyperlink to view a specific authorization, the status, Requesting Provider, and Servicing Provider.

Providers can filter their search by entering the Authorization Number (Auth No), Member ID, Member Name, Status (Pended, Approved, Denied), Received Date, Date of Service, Decision Date, and then click [search icon] to filter your search. Once filtered, you may download the file into a CSV by clicking the EXPORT icon.

To submit a new authorization request click the NEW icon.

When submitting a new authorization, **the form will require member verification by entering the Member ID#, First/Last Name, or Date of Birth (DOB)**.

The form will then provide the user with the Member's PCP Group Name, PCP Group NPI#, PCP phone number, PCP fax number, and the member's eligibility effective dates.

Once entered, choose your **authorization type** (18-1, 20-1, 50-1, RAF) via the drop down arrow, and the form will auto populate with the field requirements.

Treatment Authorization Request (TAR 50-1) is submitted by the requesting provider for medical services including physician-administered-drugs, which need to be reviewed for medical necessity and appropriateness of care by CenCal Health.

Extension of Stay in Hospital 18-1 form is used to determine the medical necessity for admission and for continued acute care and to facilitate a transfer or transition of care. This should be submitted by the Admitting inpatient hospital, rehab clinic, or Long Term Acute Care (LTAC) facility.

LTC Authorization 20-1 form is used to determine the medical necessity for admission and for continued stay in a skilled nursing facility, subacute care, and a congregate living health facility, and should be submitted only by those facilities.

Referral Authorization Form (RAF) allows a PCP Group to refer their assigned members to a Specialist for consultation.

Then you will enter the **'Start Date' and 'Expiration Date'** for your authorization. The users contact information will auto populate based off of the users access and will allow CenCal Health Medical Management Department to contact you for additional details (as needed).

Category drop down will allow the user to determine the following:

- **Pre-service** is a prior authorization
- **Post-service** would be used for retro authorizations
- **Concurrent** is used if the member was receiving additional services
- **Pre-service/Concurrent Urgent** are for urgent requests

25

Remarks allows the user to 'Add Remarks:' specific to the service which is reviewed by our Medical Management Department.

*If you are submitting a TAR, please provide the RAF# within your medical justification notes.*

Requesting Provider is your provider group NPI# and if you have multiple NPI#'s associated to your IRS# it will provide you with a list so you can determine what site your member is assigned to.

Servicing Provider/Facility is used when a PCP is referring their member to a specialist. Users can enter a Specialist's NPI#, or search via the 🔍 icon.

Providers can search from a list of contracted CenCal Health Specialists by Plan, Area, and Specialty Type.

Click on the check box circle next to the Provider's NPI# from the list that you would like to refer to, and the providers NPI#, First Name, and Last Name will auto populate on the form then click the **Select** icon.
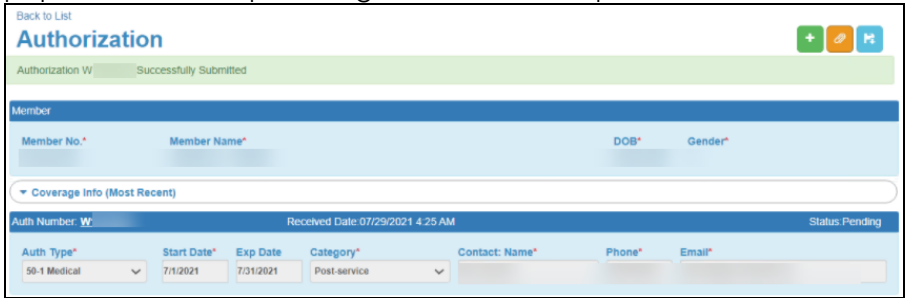
The Specialist's **Servicing Provider/Facility Info** address and phone number will populate on the form as additional verification.

Diagnosis code is required in the first Dx1 box, with following diagnostic codes as needed. You may also search by clicking on the 🔍 icon and you can search for a list of diagnosis codes.

Line Items will populate for the 50-1 Medical TAR form which requires Date(s) of Service, Service Code (procedure code or CPT code), Modifier, Units, Quantity, and Charge (billed charges).

To **submit your authorization**, click on the [icon] icon, and if submitted successfully, the authorization # will populate on the top line in green, and will be placed on the first line item within the home.
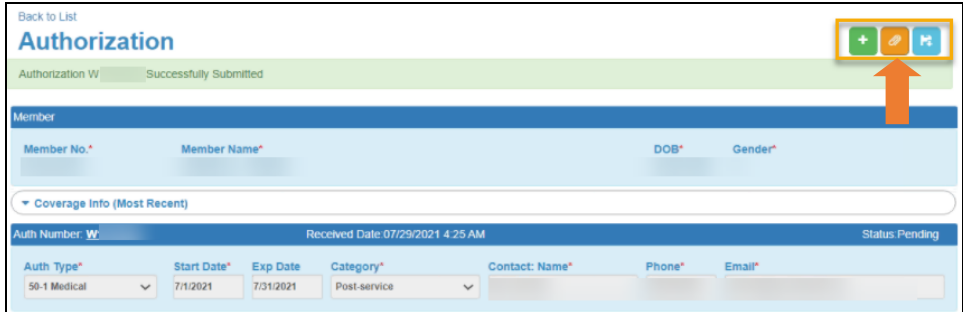

Upload Attachments

Once you save the details within your authorization, you have the ability to upload attachments for medical justification and supporting documentation so CenCal Health's Medical Management Department can further review.

Follow the steps below to attach your supporting documentation to new authorization requests.

1. Enter all pertinent information to your Authorization Form (TAR, RAF, FORM 18-1, 20-1), then click [Submit] icon button. If all information submitted is valid, the Attach Button(s) will become visible via the [icon] Attach button icon. If the authorization was not successfully submitted, the Attach Button(s) will not be visible

Click on the [icon] Add Attachment icon to upload your supporting documents.

The submitted authorization number will appear on the attachment function. Follow the steps to indicate the Category type (Initial, or Additional), and then click [Choose File] icon to upload documents from your file data source.

27

Once the document is chosen, the screen will indicate file name, and the **UPLOAD ATTACHMENT** icon button will appear once a file has been selected for upload. Click **UPLOAD ATTACHMENT** to save the document to the authorization.

Click "Choose File" and Select a file to Attach to: W⬛⬛⬛⬛   ✕

Category: ● Initial   ○ Additional

Upload File:

[Choose File Blankfw9.pdf]   [**UPLOAD ATTACHMENT**] Cancel

File Types: .pdf .jpeg .jpg .txt   Max File Size: 4MB
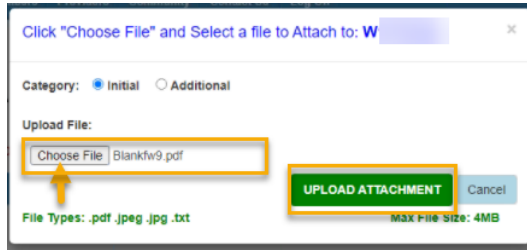
The document(s) will then be connected to your authorization.

Attachments for Auth#: W⬛⬛⬛⬛   ➕

CATEGORY	SUB CATEGORY	SOURCE	FILENAME	DESCRIPTION	CREATED_BY	CREATED_DATE	
		Portal	2019_W-2_CenCal_Health.pdf		⬛⬛⬛	12/15/2020	Download
Initial		Portal-INI	Blank_Form.pdf	Member Notes	⬛⬛⬛	12/15/2020	Download

Page 1 of 1

[1]

- Use the **Download** button to get a copy of the attached document.
- Use the ➕ button to add additional documents.
- Use the browser ← back button to return to previous page.

All files will only be accessible for download for 30days from the created date, and will show as 'Not Available' on the list above once it hits the 30 day mark. CenCal Health staff will still have access to view internally.

Procedures Requiring a Tar

Authorization

Add/View Authorizations

Procedures Requiring a TAR

Training Tutorials

UM Authorization Download Form

Certain procedures require prior authorization (i.e. Treatment Authorization Request (TAR)) before the procedure is rendered and reimbursement can be made. An authorization is needed to ensure that requested benefits are medically necessary, do not exceed benefit limits, and are the lowest cost item or service covered by the program which meets the member's medical needs.

The search tool can be used to determine whether a procedure code requires a prior authorization. The tool also provides additional information regarding the procedure code age, service, frequency, and diagnosis code limits/requirements upon claim submission. This additional information is displayed as billable units based on the procedure code description.

HCPCS/CPT Procedure Code - Prior Authorization Requirement Search Tool

Certain procedures require prior authorization (i.e. Treatment Authorization Request (TAR)) before the procedure is rendered and reimbursement can be made. An authorization is needed to ensure that requested benefits are medically necessary, do not exceed benefit limits, and are the lowest cost item or service covered by the program which meets the member's medical needs.

The search tool can be used to determine whether a procedure code requires a prior authorization. The tool also provides additional information regarding the procedure code age, service, frequency, and diagnosis code limits/requirements upon claim submission. This additional information is displayed as billable units based on the procedure code description.

Enter the Procedure Code and Date of Service you are searching, then click Submit. If you do not know the Procedure Code click the magnifying glass to search by procedure code description.

Prior Authorization tool is for TAR requirement only and not Referral Authorization Forms (RAF)s. For RAF requirements, please refer to this site or contact Medical Management at 805-562-1082.

Plan   Procedure Code   Date of Service
[Medi-Cal ▾]   [🔍]   [06/11/2021]   [SUBMIT] [RESET]

28

Enter the Procedure Code and Date of Service you are searching, then click [Submit]. If you do not know the Procedure Code click the magnifying glass to search by procedure code description.

Training Tutorials

Please watch our training tutorial videos to learn more about authorization submission. All submitted requests will receive an authorization number if submitted successfully. Use the authorization number (#) to submit clinical documentation for review if required via the attachment upload feature available for all authorization types.

- PCP Referral Authorization (RAF) Video Tutorial
- 50-1 Medical Video Tutorial
- 18-1 Inpatient Video Tutorial
- 20-1 Long Term Care (LTC) Video Tutorial
- Physician-Administered-Drug (PAD) Authorization Video Tutorial

UM Authorization Download Form

Providers have the ability to download the PDF fillable 'Authorization Request Form' to fax and/or send via the secure file drop in the event that you are unable to submit your authorization via the electronic forms. Once received CenCal Health's Medical Management Department will contact the provider staff member that submitted the form with the authorization A#, and status of the authorization request.

All authorizations submitted via the paper form are viewable via the home screen of the 'Add/View Authorizations' module to review the status.

REPORTS
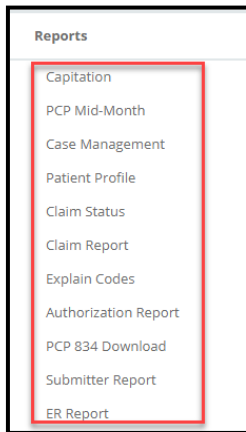
Daily Claims – Please refer to the Claims Entry section of guide.

Capitation - This PCP monthly capitation report shows member aid codes, ages, and guaranteed payment amount per member per month. Below will reflect payment of summary per PCP practice. This report can be downloaded or printed by clicking on the icon.

Pcp Mid-Month – This report outlines a PCPs new or deleted assigned members per month. This reflects changes that are made prior to the middle of each month.

Case Management – This report will show a PCPs Case Management List. You may query by plan on any month of any year.

Patient Profile –   This report shows all services performed for a particular member during a specified time period by the provider. Enter a valid member ID number, program, from/thru dates, then click on **Submit Form** for a member claim report which shows all claims you have submitted on behalf of that member. To do another report, simply click on the **Reset Form** button.

Claim Status – Allows a provider to review all claims that have been submitted to date that are payable, deniable, or pending. You select which program you wish to run the report on and the provider number.

Claim Report – Allows a provider to review large volumes of claims at once.   The maximum date span is 200 days. This report shows the same information as the Daily Claims Report but on a larger scale.

Explain Codes – This is a list of the Explain Codes which appear on the Claims Editor, Daily Claims Report, Patient and Provider Profiles, and EOBs.

Pcp 834 Download -This is a HIPAA compliant Case Management file which generates an online report.   Benefit Enrollment and Maintenance documents objective is to clarify what segments CenCal Health's 834 will contain, along with clarifying the definition of "generic fields" (i.e., group policy number).   Please click on the 'Download the SBRHA 834 Companion Guide' for more information.

Note: HIPAA is clear that member information that is sent in a file to a payer or provider must be in HIPAA format

Submitter Report – Displays a report of claims submitted through a clearinghouse by a provider and gives the claim status w/ link to edit minimal service line data and ability to reedit.

Er Report – This is an online tool for Primary Care Provider to assist in the care of their assigned members by monitoring ER usage.

COORDINATION OF CARE
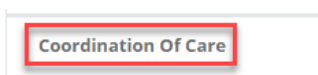
This is an online tool for Primary Care Providers to review their practice and manage the care their members are receiving.

Each report is grouped with appropriate member data and allow for individual 360 member information upon clicking on individual Member ID#.

Indicate your provider number and Month/Year in which you would like your practice reports to appear.

Practice Summary

The cover screen will automatically start with the [Practice Summary] tab.

Current Case Load Distribution & Past Three Month Trends
Here you can see how many members your practice has under the SB Medi-Cal & SLO Medi-Cal program, and the past three month trends under each program assigned to your practice.
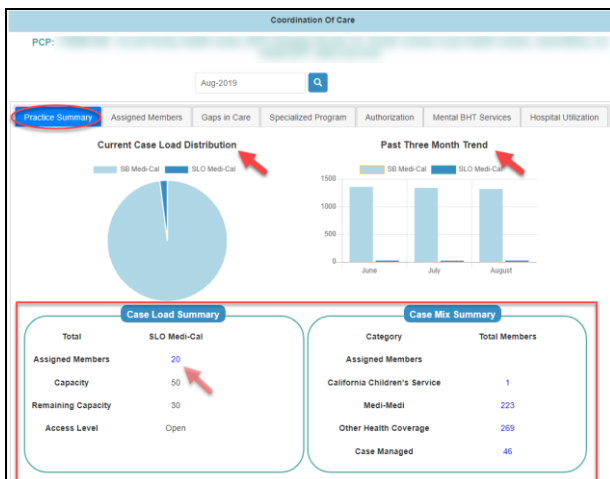
Case Load Summary
Assigned Members: Indicates the quantity of assigned members, under each plan ID (SB Medi-Cal, and SLO Medi-Cal) assigned to your practice within that date range.

Capacity: Indicates the total amount of members, under each plan ID (SB Medi-Cal, and SLO Medi-Cal), you want to manage within that date range.

Remaining Capacity: Indicates how many additional members your practice can add to your capacity list.

Access Level: EPO (Established Patients Only) & Auto Assign, under each plan ID (SB Medi-Cal, and SLO Medi-Cal) assigned to your practice within that date range.

Case Mix Summary
This box indicates a total amount of members the practice is assigned to, in the California Children's Services (CCS) program, Medi-Medi members, have Other Health Coverage, and are under Case Management.

❖ **Helpful Tip: You can click additional Member Assigned details if a number on this screen is indicated in blue.**

❖ **Helpful Top: The additional tabs below allows the user to export to CSV report by clicking on** [icon] **icon**

Assigned Members

Displays all of your assigned members with 'Continuous' care, '**New**' assigned members in green. This report also identifies which members are due for their IHA visits.

Click on the 'Show Reassigned only' button for a list of members that are no longer assigned to your practice and to see a list of ineligible members indicated in red.

All columns can be filtered per your needs, and export to a csv download by clicking on the icon.

Gaps In Care

Identifies members who are due for clinically recommended services to help Primary Care Providers continue providing high quality health care for members who are due for one or more aspects of care.

Click on the 'Clinical Recommendation' drop down to filter your 'Overdue Clinical Recommendation' member report.

Additional information on Quality of Care Reports, Gaps in Care Measures, and FAQ is available via the links on this tab.

Specialized Program

The purpose of this tab is to view all members assigned to them and see which program the member is case Managed under. The report indicates the CM Reason, Begin Date, End Date, and Case Manager Name.

Authorization Utilization

Purpose is to allow Primary Care Physicians (PCP) to manage their assigned members referral visit and check the status of each authorization, and provide follow-up care as needed. 'Visit Complete' is pulled from claims data received by CenCal Health.

Mental BHT Services

Mental/BHT referrals, authorization and coordination of services will be managed by the CenCal Health Behavioral Health delegate- The HOLMAN Group to ensure that members have access to services according to expected standards and that duplicative services are not being provided. Through this tab, Providers can View the authorization data received from The HOLMAN Group, the information of the qualified BHT provider, and the First Date of service, and data on the approval (number of days).

Hospital Utilization

Emergency Room (ER) Utilization data is based on what is reported to CenCal Health through the real-time ER data feeds by only the following in-network hospitals: Cottage Health System, Catholic Healthcare West, and Lompoc District Hospital and claims feed. As result, this report may not reflect all ER visits for your assigned members.

PROCEDURE PRICER

> Procedure Pricer

CenCal Health hopes you find this reimbursement rate information for various procedure codes useful. The reimbursement rates are the latest in CenCal Health's database for contracted providers who do not have special contracts covering the procedure codes.

The use of modifiers with the procedure codes will affect the reimbursement rates. In some cases, the member's age and status can also influence the rate. In addition, CenCal Health reserves the right to

retroactively or prospectively change the rates, and the rates may be affected retroactively or prospectively by State changes to the basic Medi-Cal rates.

After completing the necessary fields, click the button **Price It** or press the **Enter** key, and a price will appear in the field labeled **Allowable**, which is the current allowable for that particular procedure on that date of service. You may also receive messages like "not a benefit", "modifier required", or "manual pricing" in that field.

IMPORTANT REMINDER: Providers should always bill CenCal Health with their usual and customary charged amounts and not the allowable that appears on this screen or their EOBs. We are constantly changing and updating our data, including reimbursement rates, and you could short-change yourself.

SMART PROGRAMS

Diabetes Smart

SMART Programs
> Diabetes SMART
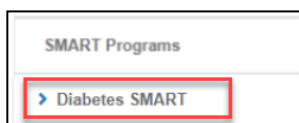
CenCal Health identifies members with certain chronic conditions and develops and implements network-based Disease Management Programs to address their health care needs. These programs work with PCPs and specialists to improve

clinical outcomes, reduce or delay long-term complications, and manage the member's care in a cost-effective manner.

This online tool allows our providers to view and submit clinical data to help you manage your members enrolled in the Diabetes SMART Program.

Using this tool, you are able to enter test dates and results for:
- Hemoglobin A1c tests (HbA1c)
- Diabetic Eye Exams
- Nephropathy screening or monitoring tests

In addition, it can be used as a report for all members assigned to you and/or who are enrolled in the Diabetes SMART program. It includes fields for annually recommended screenings that your members are due for and whether or not they've received that screening during the current calendar year.

The Diabetes SMART Clinical tool is where you will enter clinical test results for a specific member enrolled in the Diabetes SMART program, and have the ability to export to a CSV file for your own clinical reports.
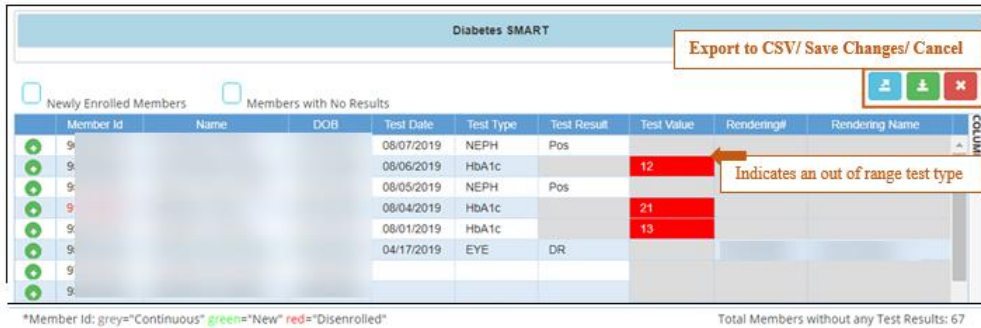

This interactive form will allow you to filter 'Newly Enrolled Members', and 'Members with No Results' by clicking the check box.

Eligible members and non-eligible members (indicated in red) are listed.

To add results for a listed member, click the ⊕ icon, and another line will appear with the member information auto populated in the fields.

Test Date	Test Type	Test Result	Test Value	Rendering#	Rendering Name

Enter the following:
1. Test Date (you can manually enter the date mm/dd/yyyy) or click from the calendar tool
2. Choose the 'Test Type' (HbA1C, NEPH, EYE)
3. Once you choose your 'Test Type' the following fields will indicate additional requirements, or 'N/A' for no additional entry required.
   o If you have an 'EYE' test type, the 'Test Result' selection of DR, or No Dr will appear and the user is required to enter the rendering provider's NPI# and/or name that performed the eye exam.

4. After entry is complete save changes by clicking ⬇ icon. To delete the line item, click ✖ icon to delete that line item.

   ❖ **Helpful Tip:** You can enter more than one line item at a time, and then click save ⬇, and all items will save to this report. In addition, if a Member ID# is indicated in red as 'Disenrolled' data can't be entered.

After entering and saving ⬇ your data, the user can export to a report by clicking the 'Export to CSV' ⬆ icon.
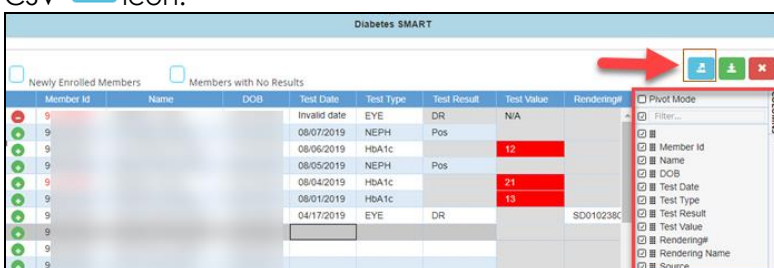
The user can also filter the rows for a personalize report for your records. These reports are useful in making sure that our members receive the correct health services during their next office visit.

DOWNLOADS
Explanation of Payments

The Explanation of Payment (EOP) is a notice of payment to claim payments. When providers submit a claim, you will receive an EOP that explains the payment and any adjustment(s) made to a payment during the adjudication of claims. Explanation of Payment (EOP) files allows providers to download their EOP Report. Once you determine the EOP file, click the [PDF icon] Download icon.

EOP Files

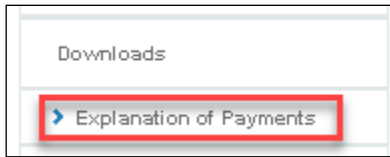| File Name	Upload Date ▲	File Size	Download
eop_____.pdf	2/27/2018 11:16:08 AM	73.58K	[PDF]
eop_____.pdf	2/27/2018 11:16:08 AM	6.05K	[PDF]
eop_____.pdf	2/27/2018 11:16:08 AM	14.3K	[PDF]

The EOP report provides justification for the payment. The explain codes in the EOP help you identify any additional action you may need to take (For example, some explain codes may indicate that you need to resubmit the claim with corrected information).

RECIPIENT NAME				RECIPIENT ID#	CLAIM#		MED.REC#			PATIENT ACCT#			
FROM DOS	THRU DRUG#	PROC	MOD RX#	QTY/ DAYS	BILLED AMOUNT	ALLOWED AMOUNT	OTHER COVERAGE	PATIENT LIABILITY	INTEREST AMOUNT	PAYMENT AMOUNT	LINE	EXPLAIN	CODES

The EOP will be available on the provider portal for up to 18 months; therefore the Providers can access a copy of historical payment EOPs as needed.

PCP REASSIGNMENT REQUESTS

On occasion, a Primary Care Physician (PCP) may encounter a situation that warrants a request to have a patient reassigned to a new PCP. Within the home module, PCP's can view submitted cases, Request Dates, Status, and Reason for reassignment.

Providers can also filter their search by entering Member ID, Case Id, Request Date Range, and status. Click the [EXPORT] icon to download your search filter to a CSV file.

Submit a New Reassignment Request

To submit a new request for an assigned member, click the [NEW] icon directly on the home screen module.

The form will require point of contact information so CenCal Health can contact you directly if additional details are required.

Member Info

Member ID# is required and the members DOB, Name, and Plan will auto populate on the form. If you have additional family members associated to this member, click

[ ] Additional Family Members box and please enter their member ID information

Case Details

Choose from the list of Reasons as to why you are reassigning this member.

Each reason will require additional details for review and/or additional date requirements.

Click 'Save' to submit your request, 'Reset' to reset the form, or 'Back' to go back to the Member Reassignment home screen module.

Requests will be reviewed by the Provider Services Department and the main point of contact listed on the form may contact you for additional clarification prior to reaching a decision. Requests submitted after the 10th of one month through the 9th of the next month are processed by the cut-off date (9th day of each month at 4pm).

PCPs may return to the website after the request has been processed to verify the status of the request.

The member's new assignment becomes effective the first day of the month following the cut-off date. The PCP who requested the reassignment continues to be responsible for the member's care until the new assignment is in effect.

If you do not have Portal access, please call Provider Services at (805) 562-1677 for further instructions.

PHARMACY FORMS

CenCal Health Medical Request Form (MRF)
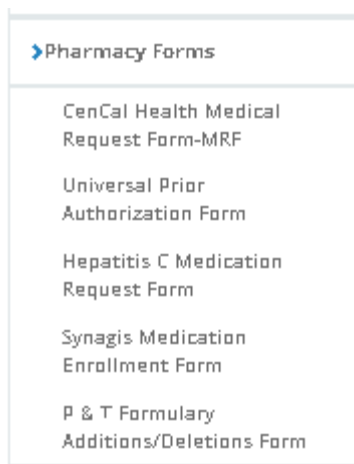
Prior Authorization form for formulary exemption, please fax all supporting documents along with the form.

Prescriptions for the following require a MRF:
- All non-formulary medications
- Brand name drugs when an equivalent generic is available except for those drugs listed as exemptions, Drugs not meeting the Code 1 restriction or Step Therapy criteria
- And/Or Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits

CenCal Health Pharmacy Authorization Form (PAF)

Exemption from the Maximum benefit of 7 medications

Hepatitis C Medication Request Form
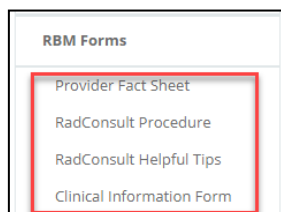
Specific MRF for Hepatitis C Medications

Synagis Medication Enrollment Form

Specific MRF for fulfillment thru CenCal Health's Specialty Pharmacy, Diplomat

P & T Formulary Additions/Deletions Form

Requests for medication reviews by CenCal Health's P&T Committee

RADIOLOGY BENEFIT MANAGER (RBM)

The Radiology Benefit Manager (RBM) process enhances the quality of services delivered to patients and reduces unnecessary radiation associated with advanced diagnostic imaging.

CenCal Health has been focusing on provider consultations and patient safety as a means to control for appropriate utilization of high-tech imaging. CenCal Health selected Care to Care, a URAC accredited as our new partner effective June 1, 2015. The goal is to improving our Radiology Benefit Management (RBM) program for high-tech imaging to enhance the quality of services delivered to patients and reduce unnecessary radiation associated with advanced diagnostic imaging.

Applicable Services

This program applies to the following outpatient services:

- Positron Emission Tomography (PET)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computed Tomography (CT)
- Computed Tomography Angiography (CTA)
- Nuclear cardiology studies

The ordering physician's office must contact Care to Care to request an authorization prior to ordering a high-tech imaging service. Based on clinical information from the physician's office, Care to Care will then make consultative determinations using the clinical guidelines published on their website.
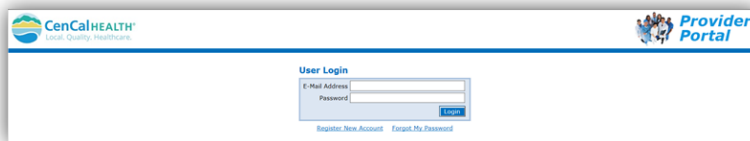
Requests can be submitted via phone, fax or through Care to Care's Care Portal
www.cencal.careportal.com

*Authorizations are valid for 90 days from the date of the consultation

Expectations

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, urgent care centers, or intra-operative procedures are excluded from the high-tech imaging consultation requirement. Imaging studies for members who have other health care coverage are excluded from the consultation process requirement.

Required Information

Consultation requests can be made to Care to Care via phone, fax or web:

Phone: 1 (888) 318-0276
Fax: 1 (888) 717-9660
Web: www.cencal.careportal.com and Care to Care's call center is open: M-F 5am – 5pm PST.

CONTACT US

If you need to give access to a separate user that have multiple accounts with other provider groups (e.i. Billers that bill for multiple providers), have questions or would like additional training please reference our website at www.cencalhealth.org/providers/provider-portal/ or email CenCal Health's Web Master at webmaster@cencalhealth.org

Medical Management (805) 562-1082
- Authorization Questions/Concerns

Provider Services Department (805) 562-1676
- Portal Error Screen Issues
- Provider Information Changes
- Training

Pharmacy Services (805) 562-1080
- PAD & MRF Questions
- Medi-Cal Rx Transition

Member Services (877) 814-1861
- Member related inquiries