CONTRA COSTA HEALTH

Instructions to complete Void and Replace Request.

Copy of form is also listed on the Shared Folder /ShareCare Files/ShareCare Tips Sheet & Bulletin/AODA-004 Rev 05-2024 AOD Service Void and Replace Request

Email completed forms to SmartCareVR@cchealth.org

Purpose: This form can be used to identify a service or multiple services requiring corrective action(s), based on a Denial or Service Error reports. (NEW)

A. Select from the following check boxes to indicate service action:
   1) **VOID/CORRECTION** – correction to the service, ie, Replacement service.
   2) **DELETE SERVICE** – service error, ie service should not have claimed.
   3) **MEDI-CAL 835 DENIAL** – correcting a billed service.
   4) **DISALLOWED** – audit determine service is not permitted.

B. Complete the information requested:
   1) Reason for Request – remarks to make this request clearer
   2) Program Name - identified the Organization requesting the service change.
   3) Reported by/Date: Who and when the request was generated
   4) Start Date/End Date – Use to identify if multiple services are part this request.

C. ***Incomplete*** or ***illegible*** forms will be returned to the originator for correction. Unclear instructions could potentially delay or prevent corrective action.

D. One form can be used to identify multiple service correction, providing the corrective action is for the same Client, or within the time span when service correction is requested. For Example:
- Delete all Services 12/1/23 – 12/4/23
- Update DOB for Services 04/2023
- Services Disallowed 01/04/23 – 01/30/23

E. Request Originator will be informed when service correction is complete.

Form Description Action:
The following items are used to VOID or make CORRECTION to a Service Record. Both columns do not need to be completed, however you must clearly identify the action required. For any changes required, use the column heading CORRECTION to show the change requested.

1) Service ID: Unique Service identifier when service is created.
   a. Cannot be modified.
2) Consumer ID: The Client ID assigned to the Consumer.
   a. Required to clearly match the Client to the Service record.
   b. Do not use this form to request Client Merges
   c. Client ID, Medical Record Number, MRN are relatively the same

3) Consumer Name: Verify the name matches the Client Information Consumer.
   a. Do not use this form to request name changes.
4) Program Name: Facility Program Name
   a. Program the client is enrolled, receiving services.
5) CIN: Client Index Number –Beneficiary identifier used for Medi-Cal coverage
   a. 9-Digit identifier (91234567A), typically beginning with the number 9 and ending with an Alpha-character.
6) Clinician Name: Provider / Staff name
   a. Primary Provider rendering services.
7) Face to Face Time: The service time duration
   a. Annotate the time duration change in correction column.
8) Start Date: The Date of Service
   a. Do not use this form to identify start time changes.
9) Procedure:
   a. List the Procedure or Service description required (TCM/ICC, Individual Counseling etc)
10) Location:
   a. Place where service is rendered.
11) ICD-10 Code:
   a. Diagnosis Code assigned the service.
   b. Billing Diagnosis must be assigned based on 1st date of service.
12) Payer Claim Number:
   a. Also known as PCCN, contained in 835 adjudications identifying the Claim Line item.
   b. Identify an Claim response from Medi-Cal DMC
13) Gender/DOB: The Gender / Data of Birth found in the MediCal site.
   a. In conjunction with Customer Demographic information.
   b. Must match the Gender/DOB identified in the Medi-Cal Eligibility
14) Consumer Demographic Updated
   a. Check box once Provider has corrected the Client information.
   b. Based on 835 Denial for incorrect Gender, DOB, SSN
   c. Do not list client's Social Security Number (SSN)*
   d. All 9's is permissible (999-99-9999 or 999999999)
15) Consumer Coverage Update
   a. Check box once Client Coverage information has been corrected.
   b. Client Medi-Cal DMC insurance plan has been reviewed and correctly updated and applied.

Medi-Cal 835 Denial – Check box for any applicable Demographic or Coverage information is your attestation that corrective actions affecting the denial record has been completed, and the claim is ready to be rebilled. rebill action:

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Do not use this form to update or modify the following:

- a) Consumer Service ID: Used to identify the individual service.
- b) Consumer ID: Also known as the Medical Record Number (MRN); **This form is not used to make changes to the Consumer MRN**
- c) Consumer Name: to ensure the MRN match and V/R is for the correct record

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SmartCare VOID & REPLACE REQUEST

This form is used to Void/Replace a service that has been claimed and or denied.

Complete information in the table below - send to SmartCare Support @ smartcaresupport@cchealth.org

☐ VOID/CORRECTION (Correction to the service) DELETE SERVICE? ☐YES ☐NO

☐ MEDI-CAL 835 DENIAL DISALLOWED? ☐YES ☐NO

Reason for Request:______________________________

Program Name: ______________________________

Reported By: ______________________________ Date:______________

Start Date : ______________________ End Date: ______________________

VOID		CORRECTION	
SERVICE ID	1	Leave this column blank if no correction is needed.	
CONSUMER ID	2	CONSUMER ID	
CONSUMER NAME	3	CONSUMER NAME	
PROGRAM NAME	4	PROGRAM NAME	
CIN	5	CIN	
CLINICIAN NAME	6	CLINICIAN NAME	
FACE TO FACE TIME	7	FACE TO FACE TIME	
START DATE	8	START DATE	
PROCEDURE	9	PROCEDURE	
LOCATION	10	LOCATION	
ICD-10 Code	11	ICD-10 Code	
Payer Claim Number	12	Payer Claim Number	
Gender/DOB	13	Gender/DOB	

Comments:

CHECK ANY APPLICABLE BOXES:

☐ Consumer Demographic Updated i.e. Gender, Address, DOB, SSN (14)

☐ Consumer Coverage Updated i.e. CIN, eligibility, Coverage Plans (15)

By checking I am confirming these fields have been updated and are ready for rebill

FOR COUNTY USE ONLY

Complete Date: ______________________________

Verify Date:

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