

MEDI-CAL POINT OF SERVICE (POS) NETWORK/INTERNET AGREEMENT

This agreement is required for all providers and non-providers (provider representatives) who intend to use the POS Network or selected Medi-Cal Web site applications at www.medi-cal.ca.gov.

I.

- (a). (The following is required only for enrolled Medi-Cal providers): The California Department of Health Services (DHS) will permit the use of the California POS Network and Medi-Cal Web site by the following Medi-Cal provider subject to the terms and conditions of this agreement.

Provider Name: _____

Medi-Cal Provider Number: _____

- (b). (The following is required only if intending to use a device and/or software that is not obtained through EDS):

Vendor/Developer Company Name: _____

CMC Submitter Number (if applicable): _____

Contact Person: _____

Phone Number: (____) _____

- (c). (The following is required only for non-provider users [provider representatives] of the POS Network): DHS will permit the use of the Medi-Cal California POS Network (Network) by the authorized provider representative _____ (Representative) subject to the terms of this agreement. Please attach to this agreement a list of all Medi-Cal provider numbers for which the non-provider user is also the authorized representative.

- ## II.
- Provider/Representative agrees to limit the usage of the POS Network and Medi-Cal Web site to the following Medi-Cal eligibility and claims-related transactions as defined in the *POS Device User Guide*, "Site Help" on the Medi-Cal Web site, or the *POS Network Interface Specifications* document:

- A. Verification of Medi-Cal eligibility
- B. Share of Cost clearance
- C. Medi-Service reservations
- D. Submission of Pharmacy claims (may only be performed by providers enrolled to submit claims on the *Pharmacy/Medical Supplies Claim Form*)
- E. Submission of ANSI ASC X12N 837 professional claims (may only be performed by providers enrolled to submit claims on the Medi-Cal Medical Services claim form)
- F. Submission of other transactions as may be subsequently permitted by DHS and as documented in one or more of the user manuals identified above or in the Publications area of the Medi-Cal Web site
- G. Browsing of Medi-Cal Web site

Provider/Representative acknowledges that failure to limit the usage of the POS Network to the transactions described above may, at a minimum, result in DHS revoking the privilege to use the POS Network. Abuse of transactions available on the Medi-Cal Web site may result in DHS revoking provider access to Medi-Cal Internet transactions.

- ## III.
- The Provider/Representative agrees that the following constitutes the only authorized methods of accessing the POS Network:

- A. Medi-Cal-provided toll-free (800) line or 916-prefix phone line as documented in the *POS Device User Guide*
- B. Provider- or Representative-provided leased phone lines

(Page 1 of 2)

IV. The Provider/Representative agrees to pay the following fees associated with the use of the POS Network:

- A. For eligibility transactions, including Share of Cost clearance and Medi-Service reservations submitted through Medi-Cal-provided phone lines, there will be no transaction fee.
- B. For Provider and/or Representative submission of pharmacy claims transactions through Medi-Cal-provided phone lines, there will be a fee of \$.10 per approved claim transaction. An approved claim transaction is defined as a service, medical supply, durable medical equipment or drug supply that is determined to be payable through the claims adjudication process of the POS Network. This fee will be withheld from your regular Medi-Cal claims payment.
- C. Any claim and/or eligibility transaction submitted on the Medi-Cal Web site will not have a transaction fee.
- D. If the POS device is not being used over a reasonable amount of time, the Provider/Representative agrees to return the device. If the device is not returned in a timely manner, the Provider/Representative agrees to have the \$700 cost of the device deducted from future reimbursement.

V. Provider/Representative agrees, in order for the Provider/Representative's system to be activated for submission of actual Medi-Cal eligibility or claims-related transactions, to perform testing as required by DHS and as documented in the *POS Network Interface Specifications* document. Provider/Representative acknowledges that multiple tests may be required to activate the full functionality of the device/software and that all testing must be successfully concluded before the device/software will be activated.

VI. Provider/Representative agrees to report all malfunctions of the POS Network or Medi-Cal Web site to EDS at the phone number and/or address documented in the *POS Network Interface Specifications* document or on the Medi-Cal Web site.

VII. Provider/Representative acknowledges that neither DHS nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHS.

VIII. Provider Signature:

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement.

| | |
|------------------------|----------------------|
| _____ | _____ |
| Printed Name of Signee | Authorized Signature |
| _____ | _____ |
| Title | Date |

VIII. Non-Provider (Authorized Representative) Signature:

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement.

| | |
|------------------------|----------------------|
| _____ | _____ |
| Printed Name of Signee | Authorized Signature |
| _____ | _____ |
| Title | Date |
| Address _____ | |
| _____ | |
| _____ | |

CMC Submitter Number (if applicable): ____ _

Please mail this completed form to:

EDS
Attn: POS/Internet Help Desk
3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017