

Alameda County Health, Behavioral Health Department (ACBHD)

SmartCare Invoice Report Training August 21, 2025



ACBHD Fiscal Updates

Spring Provider Meeting Fiscal Refresh

- Changes between ACBHD and the State, effective 7/1/23
 - As of 2023-24 California Department of Health Care Services (DHCS) reimburses ACBHD on a Fee-For-Service basis based upon rates set by DHCS. These rates vary by the Practitioner type performing the service.
 - DHCS also eliminated the requirement for cost settlements with Counties, and local match is established via Intergovernmental Transfers in place of Certified Public Expenditures.
 - 7/1/2023 ACBHD implemented the SmartCare system to align with the DHCS Payment Reform changes.
- Payment Transformation- ACBHD and CBOs FY 23-24 and 24-25 Payments/Settlement
 - More flexible invoicing options.
 - To support a more intentional transition with our CBO partners, ACBHD continued to be flexible on invoicing for FY 23-24 and FY 24-25.
 - Service Entry in SmartCare for FY 23-24 and FY 24-25 is required, as settlement or final payment provisions have not changed.
 - As of August 1st, 2025, June 2025 service data should be complete. Refer to the BHD Provider website, SmartCare Tab, for past fiscal year service entry due dates.





ACBHD Fiscal Updates

Invoice Report Go-Live

- Rate-based and Fee-For-Service reimbursement will start in September 2025, for the August 2025 service month. There are two report types available for use in SmartCare:
- Refer to your Organization's FY 25-26 Procurement Contract Exhibit B Attachment Section 2- Method of Reimbursement Rate Sheet to determine the report needed to complete your Provider Claim Template.

Invoice Report

- Invoicing rate times unit by the legacy modalities (Case Management, Mental Health Services, Medication Support, and Crisis Intervention).
- Includes Travel and documentation time in the total duration for reimbursement purposes.

Invoice Report by Practitioner

- Fee-For-Service reimbursement method for programs reimbursed by Practitioner Type/CPT code.
- Travel and Documentation Time is NOT included.



Training Agenda

- SmartCare Invoice Report Demos
 - Invoicing for Treatment Programs (Legacy by Modality Type)
 - Demo Invoice Report
 - ACBHD Invoice Template and Instructions
 - Fee-For-Service (By Practitioner Type/CPT)
 - Demo Invoice Report
 - ACBHD Invoice Template and Instructions
 - Invoice Submission
- Service Data Reconciliation
- Service Errors and Warnings
- ACBHD Tools and Resources
- Questions & Answers





FY 25-26 Procurement Contract Exhibit B Attachment - Method and Rate of Reimbursement/Rate Sheet

Invoicing for Treatment Programs (Legacy)

- BDH recommends working internally with your agency's Fiscal Manager to obtain a copy of the current contract rate sheet.
- The contract rate sheet is needed to complete the Provider Claim form.
- Review the Contracts rate sheet, Service Type/ Description column.
- Providers with legacy modalities listed in the Service Type/Description column by reimbursement method, i.e., Provisional or Negotiated rate, will use the SmartCare Report "Invoice Report (My Office)" for reimbursement.

EXHIBIT B-ATTACHMENT METHOD AND RATE OF REIMBURSEMENT Section 2: RATE SHEET

ABC Program (XY012Z)

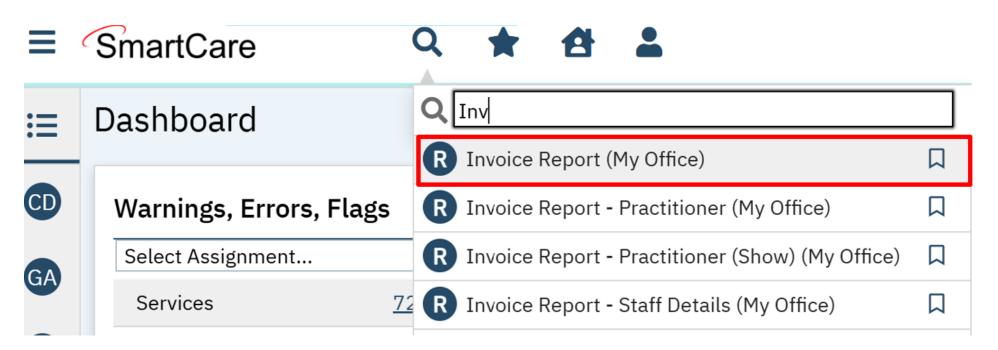
FY 2025-2026

Unit	Reimbursement Method	Rate
Per Hour	Provisional Rate	\$200.00
Per Hour	Provisional Rate	\$100.00
Per Hour	Provisional Rate	\$300.00
Per Hour	Provisional Rate	\$400.00
Per Occurrence	Negotiated Rate	\$18.89
N/A	Actual Cost	N/A
	Per Hour Per Hour Per Hour Per Hour Per Occurrence	Per Hour Provisional Rate Per Hour Provisional Rate Per Hour Provisional Rate Per Hour Provisional Rate Per Occurrence Negotiated Rate



Generating SmartCare Invoice Report

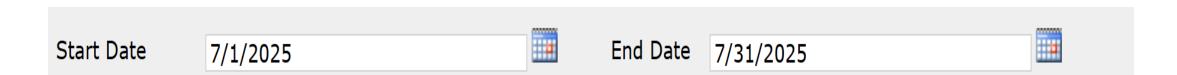
- Log in to the SmartCare system
- Once in SmartCare, search for the Invoice report by typing "Invoice" into the search bar Q
 - NOTE: By typing the first three characters, the drop-down list will begin to populate
- Select the report titled "Invoice Report (My Office)"





Generating SmartCare Invoice Report

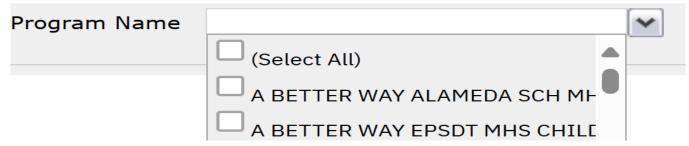
- The report pop-up box will populate in a new window
- Complete the report filters.
 - Add Start and End date.
 - For monthly Provider Claims, the date range should be for the entire service month.
 - Example, for the service period July 2025, the start and end dates will be 07/01/2025-07/31/2025.





Generating SmartCare Invoice Report

- Select the Program
 - To select programs, place a check next to the program name in the drop-down list.
 - Providers are limited to access to the Programs within their applicable CDAG permissions.
 - Providers can select as many programs as needed; there is no selection limit in the program list; however, please note that the larger the file, the longer it may take to generate.



Select View Report in the right-hand corner of the pop-up window





Generating SmartCare Invoice Report



Run Date: August 20, 2025 15:09 Created By: Diana Hernandez

Invoice Report

July 01, 2025, through July 31, 2025

ABC Program (XY012Z)

Invoice Category	Procedure Code ID	Procedure Code Name	Time(hours)	Travel Docu	imentation Time	Units	Service Count
Case Management	48	T1017 Targeted Case Mgmt (TCM)	12.63	0.83	4.98	51	17
		Case Management Total	12.63	0.83	4.98	51	17
Medication Support	774	(99212- 99215) E/M Est Office/OP (w/99415 Add-on)	4.83	0.00	2.31	9	9
		Medication Support Total	4.83	0.00	2.31	9	9
Mental Health Services (MHS)	33	H2017 Psychosocial Rehab	35.23	0.00	7.86	140	35
	64	H0032 Plan Development by Non-Physician	1.70	0.00	0.36	7	3
	67	H0031 MH Assessment non-Physician	2.50	0.00	0.42	10	2
	137	H2000 Comp. Multi-disciplinary Eval.	14.83	0.00	4.25	59	17
	523	H2017 Group Psychosocial Rehab	6.00	0.00	0.34	24	2
	783	90791 Psy. Diag. Eval. (w/T2024 Sub-Code)	2.00	0.00	3.25	2	2
	879	90832, 90834 & 90837 Psychotherapy, w/Patient (w/T2021 Sub-Code)	47.84	1.67	11.11	73	50
		Mental Health Services (MHS) Total	110.10	1.67	27.59	315	111
Total			127.56	2.50	34.88	375	137
		This report is based on "Completed" Services only as of run date	÷.				



Review Provider Claim/Service Report (Invoice) Template and instructions

- After you generate your Invoice report and review it for completeness and accuracy, it is now time to fill in your service information on the ACBHD Provider Claim form.
- Documents needed to complete Provider Claim Form-
 - FY 25-26 Procurement Contract Exhibit B Attachment Method and Rate of Reimbursement/Rate Sheet
 - SmartCare Invoice Report
 - Travel time documentation time supporting documentation
 - Actual Cost Statement of Activities/ Line Items details
 - Additional supporting documentation as required for Provider Claim reimbursement (as listed/approved in the Procurement contract)
- · Complete your invoice template setup using the contract rate sheet-
 - Complete the Unique claim fields and the Contact and Billing Information section
 - Once you have added your rates to your claim template
 - Enter the information as shown on the SmartCare Invoice Report



Review Provider Claim/Service Report (Invoice) Template and instructions

ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMENT BEHAVIORAL HEALTH PROGRAMS BEROVIDER CLAIM ASERVICE REPORT

EXHIBIT B-ATTACHMENT
METHOD AND RATE OF REIMBURSEMENT
Section 2: RATE SHEET

ABC Program (XY012Z)

FY 2025-2026

Service Type / Description	Unit	Reimbursement Method	Rate
Outpatient Services			
Case Management	Per Hour	Provisional Rate	\$200.00
Mental Health Services	Per Hour	Provisional Rate	\$100.00
Crisis Intervention	Per Hour	Provisional Rate	\$300.00
Medication Support	Per Hour	Provisional Rate	\$400.00
Interactive Complexity	Per Occurrence	Negotiated Rate	\$18.89
Other Services/ Expenditures			
Other Services/ Expenditures	N/A	Actual Cost	N/A

rovider Name: ABC Non-Profit Company ype of Contract (Master or SAN): emittance Address: 567 Magic Kingdom Lane akland CA, 94601 Illing Contact Name: Mickey Mouse Mail: Mokey Mouse PROGRAM NAME	Units tir at	ABC Progr XY0122			Month/Y Check O Origi	nal Submiss sed Submiss	ce:		
emittance Address: 567 Magic Kingdom Lane akland CA, 94601 Illing Contact Name: Mickey Mouse Mail: Mokeu/Meuahoo.com. PROGRAM NAME PROGRAM NUMBER	Units	XY0122			Check O Origi Revi Phone Nun	ne: nal Submiss sed Submis: nber:	sion	X 555	
567 Magic Kingdom Lane akland CA, 94601 Illing Contact Name: Mickey Mouse Mail: Mokey Mouse PROGRAM NAME PROGRAM NAME PROGRAM NAME PROGRAM NAME PROGRAM NAME	Units tir at	XY0122			Origi Revi Phone Nun	nal Submiss sed Submiss		555	
illing Contact Name: Mickey Mouse Mail: Molechine Manage PROGRAM NAME PROGRAM NUMBER tental Health Services [including travel and documentation in the content of the co	Units tir at	XY0122			Revi	sed Submis:		555	
Illing Contact Name: Mickey Mouse Mail: Mickey Mouse PROGRAM NAME PROGRAM NUMBER Idental Health Services [including travel and documentation]	Units tir at	XY0122			Phone Nun	nber:			
Mail: <u>Medicel/Métuahos.com</u> PROGRAM NAME PROGRAM NUMBER Iental Health Services (including travel and documentation to	Units tir at	XY0122							
PROGRAM NAME PROGRAM NUMBER Including travel and documentation to	Units tir at	XY0122			FAX Number	er:	(510)111-111	11	
PROGRAM NUMBER	Units tir at	XY0122							
PROGRAM NUMBER	Units tir at	XY0122							
lental Health Services (including travel and documentation	Units tir al								
	al		Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
		100.00	0.00		0.00	0.00		0.00	0.00
ase Management/Brokerage (including travel and document risis Intervention (including travel and documentation time)		200.00 300.00	0.00		0.00	0.00		0.00	0.00
ledication Support (including travel and documentation time		400.00	0.00		0.00	0.00		0.00	0.00
eer Support utreach & Engagement (including MAA) - Rate Based		0.00	0.00		0.00	0.00		0.00	0.00
lient Support Services (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
BS	LIST BORDS	0.00	0.00	LIXY BORRS	0.00	0.00	LIET BORRE	0.00	0.00
otal Services - Actual Cost Programs Only upplemental Falt Rate - Interactive complexity	ADOTE	18.89	0.00	4007E			ADOTE		
lient Support Expenditures - Actual Cost		10.00	0.00						
HSA One-Time Expenses - Actual Cost									
leasure A Non-Medi-Cal Eligible Expenses - Actual Cost tutreach & Engagement (including MAA) - Actual Cost									
alWORKs Engagement Fee		100.00	0.00		100.00	0.00		100.00	0.00
alWORKs Initial Reporting Fee		50.00	0.00		50.00	0.00		50.00	0.00
alWORKs Follow-Up Reporting Fee upplemental Falt Rate - Interactive complexity		25.00 0.00	0.00		25.00 0.00	0.00		25.00 0.00	0.00
Hour Care		0.00	0.00		0.00	0.00		0.00	0.00
ay Treatment		0.00	0.00		0.00	0.00		0.00	0.00
ther (must be specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
DTAL GROSS CLAIM			0.00			0.00]		0.00
ESS REVENUE:							1		
MEDICARE OTHER HEALTH COVERAGE							1		
OTHER REVENUE									
DTAL REVENUE DEDUCTED			0.00			0.00]		0.00
ET PROGRAM CLAIM			0.00			0.00]		0.00
ote: Use Claim-Page 2 if contract has more than three programs.						Total Net Pro		x:	0.00
						Less Cash Ad	dvance Rei	mburseme	nt:
						Payment Due:		- 1	0.00
hereby attest that the information contained in this docume evenue generated in the performance of the services as state uthorized Signature:	ed in the co	ntract agai	nst which this	claim is b	ncurred an eing mad	d e.	Date:		
rinted Name:							Title:		



Provider Claim/Service Report (Invoice) Template and instructions

	UNTY HEALTH BEHAVIORAL HEA BEHAVIORAL HEALTH PROGRA PROVIDER CLAIM / SERVICE REP	MS	Page1 of2	Behavioral Health Department Alameda County Health					Augu	ust :
Provider Name: ABC Non-Profit Company		Provider's Claim Number:	7312025							
Type of Contract (Master or SAN):	Master	Month/Year of Service:	Jul-25	-		Invoice Report				
Remittance Address:		Check One:				July 01 2025 through July 2	1 2025			
4567 Magic Kingdom Lane Oakland CA, 94601		Original Submission Revised Submission	X			July 01, 2025, through July 3	1,2023			
Billing Contact Name: Mickey Mouse		Phone Number: (510)	555-5555			ABC Program (XY0122	<u>"</u>)			
E-Mail: MickeyM@yahop.com.			111-1111							
PROGRAM NAM	_			Invoice Category	Procedure Code ID	Procedure Code Name	Time(hours)	Travel Docu Time	umentation Time	
PROGRAM NUMBE	Units Rate Gross Claim	Units Rate Gross Claim Uni		Case Management	48	T1017 Targeted Case Mgmt (TCM)	12.63	0.83	4.98	
Mental Health Services (including travel and documentation Case Management/Brokerage (including travel and documentation)	ntal 12.63 200.00 2,526.00	0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00			Case Management Total	12.63	0.83	4.98	
Crisis Intervention (including travel and documentation time Medication Support (including travel and documentation time	ne) 4.83 400.00 1,932.00	0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00	Medication Support	774	(99212- 99215) E/M Est Office/OP (w/99415 Add-on)	4.83	0.00	2.31	
Peer Support Outreach & Engagement (including MAA) - Rate Based Client Support Services (MHSA or Adult Service Team)	0.00 0.00 0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00 0.00 0.00			Medication Support Total	4.83	0.00	2.31	
TBS Total Services - Actual Cost Programs Only	0.00 0.00	0.00 0.00 0.00 0.00	0.00 0.00	Mental Health Services (MHS)	33	H2017 Psychosocial Rehab	35.23	0.00	7.86	
Supplemental Falt Rate - Interactive complexity Client Support Expenditures - Actual Cost	18.89 0.00				64	H0032 Plan Development by Non-Physician	1.70	0.00	0.36	
MHSA One-Time Expenses - Actual Cost Measure A Non-Medi-Cal Eligible Expenses - Actual Cost										
Outreach & Engagement (including MAA) - Actual Cost CalWORKs Engagement Fee	100.00 0.00	100.00 0.00	100.00 0.00		67	H0031 MH Assessment non-Physician	2.50	0.00	0.42	
CalWORKs Initial Reporting Fee CalWORKs Follow-Up Reporting Fee	50.00 0.00 25.00 0.00	50.00 0.00 25.00 0.00	50.00 0.00 25.00 0.00		137	H2000 Comp. Multi-disciplinary Eval.	14.83	0.00	4.25	
24 Hour Care Day Treatment	0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00		523	H2017 Group Psychosocial Rehab	6.00	0.00	0.34	
Other (must be specifically authorized in contract)	0.00 0.00	0.00 0.00	0.00 0.00		783	90791 Psy. Diag. Eval. (w/T2024 Sub-Code)	2.00	0.00	3.25	
TOTAL GROSS CLAIM LESS REVENUE: MEDICARE	15,468.00	0.00	0.00		879	90832, 90834 & 90837 Psychotherapy, w/Patient (w/T2021 Sub-Code)	47.84	1.67	11.11	
OTHER HEALTH COVERAGE OTHER REVENUE						Mental Health Services (MHS) Total	110.10	1.67	27.59	
TOTAL REVENUE DEDUCTED	0.00	0.00	0.00	Total			127.56	2.50	34.88	
NET PROGRAM CLAIM	15,468.00	0.00	0.00			This report is based on "Completed" Services only as of run date	<u>ē.</u>			
Note: Use Claim-Page 2 if contract has more than three programs	<u>s.</u>	Total Net Program (Total of All Pages) Less Cash Advance Payment Due:				am is rate based , enter t im form will calculate the				
I hereby attest that the information contained in this docum revenue generated in the performance of the services as sto Authorized Signature:		n is being made	:	Gross	Clair	n column.			Behavioral Departmen	

Run Date:

Service

Count

35

50

111

August 20, 2025 15:09 Diana Hernandez

Units

51

51

9

9

7

10 59

24

2

73

315

375

140

Behavioral Health Department

Provider Claim/Service Report (Invoice) Template and instructions

		BEHAVIO	RAL HEAL	VIORAL HE TH PROGE SERVICE RE	RAMS	EPARTM	ENT			
Provider Name:	ABC Non-Profit Company					Provider	's Claim Nur	mber:	7312025	
Type of Contract (M	laster or SAN):	Master				Month/Ye	ear of Service	ce:	Jul-25	
Remittance Address	s:					Check O	ne:			
4567 Magic Kingdor	n Lane					•	nal Submiss		X	
Oakland CA, 94601						Revi	sed Submis	sion		
Billing Contact Name:	Mickey Mouse					Phone Num	nber:	<u>(510)555-5</u>	555	
E-Mail:	MickeyM® yahoo.com					FAX Numbe	er:	<u>(510)111-11</u>	11	
	PROGRAM NAME:		ABC Program	n						
	PROGRAM NUMBER:		XY012Z							
4	Colored and decrease of the	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
	s (including travel and documentation time kerage (including travel and documentatio		7+27.29 200.00	13,906.00 3,688.00		0.00	0.00		0.00	0.00
	cluding travel and documentation time)	10.44	300.00	0.00		0.00	0.00		0.00	0.00
	ncluding travel and documentation time)	7.14	400.00	2,856.00		0.00	0.00		0.00	0.00
eer Support			0.00	0.00		0.00	0.00		0.00	0.00
Outreach & Engageme	ent (including MAA) - Rate Based es (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
nent заррак зегчісе BS	ES (MILISA DI AUGIL SELVICE TEATI)		0.00	0.00		0.00	0.00		0.00	0.00
	l Cost Programs Only	LIST BORES			LIST BORES			LUST MORRS		
	e - Interactive complexity		18.89	0.00						
lient Support Expend										
MHSA One-Time Expe										
	Cal Eligible Expenses - Actual Cost									
Jutreach & Engageme CalWORKs Engageme	ent (including MAA) - Actual Cost		100.00	0.00		100.00	0.00		100.00	0.00
CalWORKs Initial Repo			50.00	0.00		50.00	0.00		50.00	0.00
alWORKs Follow-Up			25.00	0.00		25.00	0.00		25.00	0.00
4 Hour Care			0.00	0.00		0.00	0.00		0.00	0.00
Day Treatment			0.00	0.00		0.00	0.00		0.00	0.00
Other (must be specifi	cally authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
OTAL GROSS CLAIM			I	20,450.00			0.00		[0.00
ESS REVENUE:								1	1	
MEDICARE OTHER HEALTH COVI	EDACE							-	-	
OTHER REVENUE	ENAGE								1	
OTAL REVENUE DEDUC	TED			0.00			0.00		[0.00
IET PROGRAM CLAIM			i	20,450.00			0.00	1	-	0.00
				20,100,00				_		
Note: Use Claim-Page 2 i	if contract has more than three programs.						Total Net Pro (Total of All Pag		c [20,450.00
							Less Cash Ad	dvance Rei	nbursemen	t:
							Payment Due:		[20,450.00
	information contained in this document ac the performance of the services as stated in									
Authorized Signature:	(must match CBO Sigr	ahira A.at	orization fo	n on file with	CBHD			Date:		
	(must match CBU Sign	ature Auth	orization form	n on file with A	ICBHDJ					
Printed Name:								Title:		

Behavioral Health Department Alameda County Health					Aug	ust 20, 2025	ted By:
		Invoice Report					
		July 01, 2025, through July 3	1, 2025				
		ABC Program (XY0122	Z)				
Invoice Category	Procedure Code ID	Procedure Code Name	Time(hours)	Travel Doo	cumentation Time	Units	Service Count
Case Management	48	T1017 Targeted Case Mgmt (TCM)	12.63	0.83	4.98	51	17
		Case Management Total	12.63	0.83	4.98	51	17
Medication Support	774	(99212- 99215) E/M Est Office/OP (w/99415 Add-on)	4.83	0.00	2.31	9	9
		Medication Support Total	4.83	0.00	2.31	9	9
Mental Health Services (MHS)	33	H2017 Psychosocial Rehab	35.23	0.00	7.86	140	35
	64	H0032 Plan Development by Non-Physician	1.70	0.00	0.36	7	3
	67	H0031 MH Assessment non-Physician	2.50	0.00	0.42	10	2
	137	H2000 Comp. Multi-disciplinary Eval.	14.83	0.00	4.25	59	17
	523	H2017 Group Psychosocial Rehab	6.00	0.00	0.34	24	2
	783	90791 Psy. Diag. Eval. (w/T2024 Sub-Code)	2.00	0.00	3.25	2	2
	879	90832, 90834 & 90837 Psychotherapy, w/Patient (w/T2021 SubCode)	47.84	1.67	11.11	73	50
		Mental Health Services (MHS) Total	110.10	1.67	27.59	315	111
Total			127.56	2.50	34.88	375	137
		This report is based on "Completed" Services only as of run date	e.				

Enter Travel Time and Documentation Time, when applicable.



Provider Claim/Service Report (Invoice) Template and instructions

Master		BEHAVIO	RAL HEAI	VIORAL HE LTH PROGE SERVICE RI	RAMS	DEPARTI	IENT		· ago _	_1_ of2_
Check One:										
Mickey Mouse	Type of Contract (Master or SAN):	Master				Month/Y	ear of Servi	ce:	Jul-25	
Procedum										
Phone Number:						_			X	
PROGRAM NAME PROG	Sakianu CA, 54601					Revi	seu subinis:	sion ,		
PROGRAM NUMBER: XY012Z Mental Health Services (including travel and documentation by 139.05 109.05 139.05 109.05 109.05 0.00 0.	Billing Contact Name: Mickey Mouse					Phone Nun	nber:	(510)555-5	555	
PROGRAM NUMBER Syr013Z White Base Gross Claim Units Base Gross Claim Control	-Mail: MickeyM@yahoo.com					FAX Numb	er:	(510)111-11	11	
Units Part	PROGRAM NAME:		ABC Prograi	m						
Units Park Cross Claim Units	PROGRAM NUMBER:									
Case ManagementBrokerage (including travel and documental 18.44 200.00 3.688.00 0.0					Units			Units		Gross Claim
Comment Comm										0.00
Deer Support	Crisis Intervention (including travel and documentation time)		300.00	0.00		0.00	0.00		0.00	0.00
Detre St. R. Engagement (including MAA) - Flate Based		7.14								0.00
Client Support Services (MHSA or Adul Service Team)	Peer Support									0.00
O.00	Client Support Services (MHSA or Adult Service Team)									0.00
Supplemental Falt Rate - Interactive complexity 18.89 0.00	99						0.00			0.00
Start Support Expenditures - Actual Cost		ADOVE	40.00		ADOTE			ADOTE		
##SA Cne-Time Expenses - Actual Cost			18.89	0.00						
Measure A Non-Medi-Cal Eligible Expenses - Actual Cost										
Compare 100.00 0.00 100.00 0.00 100.00 0.00 100.00 0.0										
Color Colo										
All Not Care										0.00
Manu Care										
Date (must be specifically authorized in contract) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.										0.00
Authorized Signature: [ESS REVINUE: MEDICARE OTHER HEALTH COVERAGE OTHER REVENUE MEDICARE OTHER REVENUE MEDICARE OTHER REVENUE OTHER REV										0.00
LESS REVENUE: MEDICARE OTHER REALTH COVERAGE OTHER REVENUE OTHER REVENU	Other (must be specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
MEDICARE OTHER REALTH COVERAGE OTHER REVENUE				20,450.00			0.00]		0.00
OTHER REAL TH COVERAGE OTHER REVENUE OTHER R					1			1		
OTHER REVENUE DEDUCTED 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0										
Authorized Signature: (must match CBO Signature Authorization form on file with ACBHD) 0.00 0								1		
Note: Use Claim-Page 2 if contract has more than three programs. Total Net Program Claim: 20,450.0 (Total of All Pages) Less Cash Advance Reimbursement: Payment Due: 20,450.0 Nereby attest that the information contained in this document accurately and truthfully reflects the costs incurred and everue generated in the performance of the services as stated in the contract against which this claim is being made. Authorized Signature:	TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
Less Cash Advance Reimbursement: Payment Due: 20,450.0 hereby attest that the information contained in this document accurately and truthfully reflects the costs incurred and everue generated in the performance of the services as stated in the contract against which this claim is being made. Authorized Signature:	NET PROGRAM CLAIM			20,450.00			0.00]		0.00
Payment Due: 20,450.0 I hereby attest that the information contained in this document accurately and truthfully reflects the costs incurred and everue generated in the performance of the services as stated in the contract against which this claim is being made. Authorized Signature:	Note: Use Claim-Page 2 if contract has more than three programs,								n:	20,450.00
I hereby attest that the information contained in this document accurately and truthfully reflects the costs incurred and revenue generated in the performance of the services as stated in the contract against which this claim is being made. Authorized Signature: [must match CBD Signature Authorization form on file with ACBHD]							Less Cash A	dvance Rei	mburseme	nt:
revenue generated in the performance of the services as stated in the contract against which this claim is being made. Authorized Signature: Date:							Payment Due:			20,450.00
(must match CBO Signature Authorization form on file with ACBHD)										
		ature Auth	norization for	m on file with	ACBHDI			Date:		
Printed Name: Title:					,					
	Printed Name:							Title:		

EXHIBIT B-ATTACHMENT METHOD AND RATE OF REIMBURSEMENT Section 2: RATE SHEET

ABC Program (XY012Z)

FY 2025-2026

Service Type / Description	Unit	Reimbursement Method	Rate
Outpatient Services			
Case Management	Per Hour	Provisional Rate	\$200.00
Mental Health Services	Per Hour	Provisional Rate	\$100.00
Crisis Intervention	Per Hour	Provisional Rate	\$300.00
Medication Support	Per Hour	Provisional Rate	\$400.00
Interactive Complexity	Per Occurrence	Negotiated Rate	\$18.89
Other Services/ Expenditures			
Other Services/ Expenditures	N/A	Actual Cost	N/A

If the "reimbursement method" is "actual cost," list the total actual costs for the month on the applicable line of the claim form.

TOTAL REVENUE DEDUCTED

Note: Use Claim-Page 2 if contract has more than three programs

Provider Claim/Service Report (Invoice) Template and

instructions Page __1__ of __2__ ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMENT BEHAVIORAL HEALTH PROGRAMS PROVIDER CLAIM / SERVICE REPORT Provider Name: ABC Non-Profit Company Provider's Claim Number: Type of Contract (Master or SAN): Month/Year of Service: Remittance Address: Check One: 4567 Magic Kingdom Lane **Original Submission** Oakland CA, 94601 Revised Submission Billing Contact Name: (510)555-5555 FAX Number: (510)111-1111 PROGRAM NAME: ABC Program PROGRAM NUMBER Mental Health Services (including travel and documentation tir 139.06 100.00 13,906.00 Case Management/Brokerage (including travel and documental 200.00 3,688.00 0.00 Crisis Intervention (including travel and documentation time) 0.00 0.00 0.00 400.00 2.856.00 0.00 0.00 0.00 0.00 0.00 Outreach & Engagement (including MAA) - Rate Based 0.00 0.00 0.00 0.00 0.00 Client Support Services (MHSA or Adult Service Team) 0.00 0.00 0.00 0.00 0.00 0.00 Total Services - Actual Cost Programs Only 18.89 Supplemental Falt Rate - Interactive complexity Client Support Expenditures - Actual Cost MHSA One-Time Expenses - Actual Cost Measure A Non-Medi-Cal Eligible Expenses - Actual Cost Outreach & Engagement (including MAA) - Actual Cost CalWORKs Engagement Fee 50.00 50.00 0.00 50.00 0.00 CalWORKs Initial Reporting Fee 0.00 CalWORKs Follow-Up Reporting Fee 25.00 25.00 25.00 0.00 0.00 0.00 0.00 0.00 Other (must be specifically authorized in contract) TOTAL GROSS CLAIM 20,450.00 0.00 0.00 LESS REVENUE OTHER HEALTH COVERAGE

		(Total of All Pages)	
		Less Cash Advance Reimburseme <u>nt:</u>	
		Payment Due:	20,450.00
	n contained in this document accurately and truthfully reflects the costs incurred a nance of the services as stated in the contract against which this claim is being made		
Authorized Signature:	(must match CBO Signature Authorization form on file with ACBHD)	Date:	
Printed Name:		Title:	
		Rev.	07/1/2025

0.00

0.00

Total Net Program Claim:

0.00



Submit Claims to Accounts Payable (AP) - ACBHD

- Reminder This is a restructured process between:
 - Accounts Payable (AP) ACBHD
 - Disbursement Division Alameda County Auditor Controller's office

Submit claims/questions to the AP Unit at:

CBOPayment@acgov.org

- Always copy your fiscal contract manager
- CalWORKS/Grant program invoices due 10 Days after end of service month, or by earlier Grant deadline if communicated by ACBHD
- Templates, we will follow up with a communication around how to receive Provider Claim templates.
- Current insurance on file; Exhibit C must be current, or there will be an issue getting your voucher processed.



Payment Transformation – Moving towards FFS (Invoice Report by Practitioner Type)

Spring Provider Meeting Fiscal Refresh

- Full-Service Partnership (FSP), Mental Health Plan (MHP) FFS and Opioid Treatment Program (OTP) Pilots
 - In FSP, MHP FFS and OTP Services-As-Needed (SAN) Pools
 - FFS Rates By Service Modality (FSPs); By CPT Code (MHP FFS and OTPs)
 - Cost Settlement not required for Medi-Cal Treatment
- Early adoption for School-Linked Services (SLS) and MHP FFS CBOs
 - Additional SAN Pool will be created for FY 25-26 (4 SLS providers, 6 MHP FFS)
 - FFS Rates by CPT Code
 - Cost Settlement not required for Medi-Cal Treatment



FY 25-26 Procurement Contract Exhibit B Attachment - Method and Rate of Reimbursement/Rate Sheet

Invoicing for Treatment Programs (By Practitioner)

- BDH recommends working internally with your agency's Fiscal Manager to obtain a copy of the current contract rate sheet.
- The contract rate sheet is needed to complete the Provider Claim form.
- Review the Contracts rate sheet, Provider Type column.
- Contract rate sheets with Provider Type column and Provider rates by minutes, Individual, and Group, will use the SmartCare Invoice Report – Practitioner (My Office).

EXHIBIT B ATTACHMENT METHOD AND RATE OF REIMBURSEMENT RATE SHEET

EFFECTIVE 7/1/2025

Contract Reimbursement shall be limited to codes in the QA Manual: ACBHD Procedure Code Table

(https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm) and ACBHD Billing System for each contracted program.

Rates are listed at the per minute rate by practitioner type and will be reimbursed based upon the corresponding duration, or flat fee, per billing code.

Interactive Complexity rate of \$18.89 for FY 25-26 was determined by the California Department of Health Care Services (DHCS) and shall be superseded by subsequent updates posted by DHCS at:

https://www.dhcs.ca.gov/services/MH/Pages/medicalbehavioral-health-fee-schedulesmain.aspx.

Program 789 (LMN567P)

Contractor:

Contractor.					
		ovider ites by	Provider Rates by Minute		
Provider Type		linute			
	Ind	ividual	Group		
Certified AOD Counselor	\$	-			
Clinical Nurse Specialist	\$	8.11	\$	1.80	
Community Health Worker	\$	-			
LCSW/LPHA (Licensed, Waivered or Registered)	\$	4.24	\$	0.94	
Licensed Physician/Psychiatrist	\$	16.31	\$	3.62	
Licensed Psychiatric Technician	\$	2.98	\$	0.66	
Licensed Vocational Nurse	\$	3.48	\$	0.77	
MFT/LPCC (Licensed, Waivered or Registered)	\$	4.24	\$	0.94	
Medical Assistant	\$	2.39			
Mental Health Rehabilitation Specialist	\$	3.19			
Nurse Practitioner	\$	8.11	\$	1.80	
Occupational Therapist	\$	5.65	\$		
Other Qualified Practitioner	\$	3.19		0.66	
Peer Recovery/Support Specialist	\$	-	\$	-	
Physician Assistant	\$	7.31	\$	1.63	
Psychologist (Licensed or Waivered)	\$	6.56	\$	1.46	
Registered Nurse	\$	6.62	\$	1.47	
Registered Pharmacist	\$	7.81	\$	1.73	

Flat Fee CPT Codes/ Supplemental Services		Provider Flat Rate
---	--	-----------------------

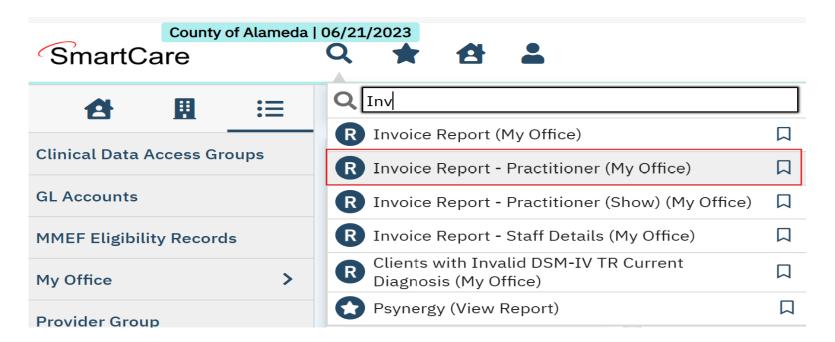
Interactive Complexity (All Types)

\$18.89 \$18.89

Behavioral Health
Department

Generating SmartCare Invoice Report

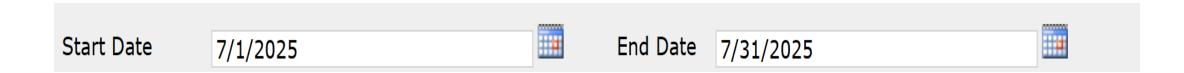
- Log in to the SmartCare system
- Once in SmartCare, search for the Invoice report by typing "Invoice" into the search bar Q
 - NOTE: By typing the first three characters, the drop-down list will begin to populate
- Select the report titled "Invoice Report Practitioner (My Office)"





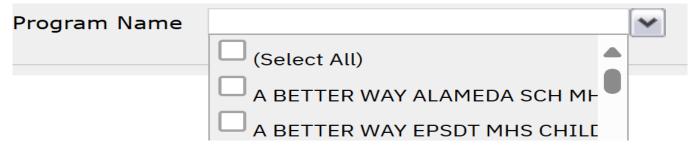
Generating SmartCare Invoice Report

- The report pop-up box will populate in a new window
- Complete the report filters.
 - Add Start and End date.
 - For monthly Provider Claims, the date range should be for the entire service month.
 - Example, for the service period July 2025, the start and end dates will be 07/01/2025-07/31/2025.



Generating SmartCare Invoice Report

- Select the Program
 - To select programs, place a check next to the program name in the drop-down list.
 - Providers are limited to access to the Programs within their applicable CDAG permissions.
 - Providers can select as many programs as needed; there is no selection limit in the program list; however, please note that the larger the file, the longer it may take to generate.



Select View Report in the right-hand corner of the pop-up window



Generating SmartCare Invoice Report



Run Date: August 21, 2025 03:13 Created By: Shukura Reynolds

Invoice Report By Practitioner

July 01, 2025, through July 31, 2025

Program 789 (LMN567P)

Practitioner	Procedure Code ID	Procedure Code Name	Time(hours)	Travel Time	Documentation Time	Units	Billable Minutes	Service Count
Mental Health Rehab	33	H2017 Psychosocial Rehab	2.27	0.00	0.28	9	135	3
Specialist		Mental Health Rehab Specialist Total	2.27	0.00	0.28	9	135	3
Other Qualified Practitioner	33	H2017 Psychosocial Rehab	0.99	0.00	0.25	4	60	2
		Other Qualified Practitioner Total	0.99	0.00	0.25	4	60	2
Other Qualified Practitioner	523	H2017 Group Psychosocial Rehab	5.17	0.00	0.66	21	315	5
Group		Other Qualified Practitioner Group Total	5.17	0.00	0.66	21	315	5
Social Worker	48	T1017 Targeted Case Mgmt (TCM)	0.60	0.00	0.13	2	30	1
	879	90832, 90834 & 90837 Psychotherapy, w/Patient (w/T2021 Sub-Code)	1.21	0.00	0.43	1	30	3
		Social Worker Total	1.81	0.00	0.56	3	60	4
Total			10.24	0.00	1.75	37	570	14

This report is based on "Completed" Services only as of run date



Review Provider Claim/Service Report (Invoice) Template and instructions

- After you generate your Invoice report and review it for completeness and accuracy, it is now time to fill in your service information on the ACBHD Provider Claim form.
- Documents needed to complete Provider Claim Form-
 - FY 25-26 Procurement Contract Exhibit B Attachment Method and Rate of Reimbursement/Rate Sheet
 - SmartCare Invoice Report
 - Actual Cost Statement of Activities/ Line Items details
 - Additional supporting documentation as required for Provider Claim reimbursement (as listed/approved in the Procurement contract)
- Complete your invoice template setup using the contract rate sheet-
 - Complete the Unique claim fields and the Contact and Billing Information section
 - Once you have added your rates to your claim template
 - Enter the information as shown on the SmartCare Invoice Report



Review Provider Claim/Service Report (Invoice) Template and instructions

EXHIBIT B ATTACHMENT METHOD AND RATE OF REIMBURSEMENT RATE SHEET

EFFECTIVE 7/1/2025

Contract Reimbursement shall be limited to codes in the QA Manual:

ACBHD Procedure Code Table

(https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm) and ACBHD Billing System for each contracted program.

Rates are listed at the per minute rate by practitioner type and will be reimbursed based upon the corresponding duration, or flat fee, per billing code.

Interactive Complexity rate of \$18.89 for FY 25-26 was determined by the California Department of Health Care Services (DHCS) and shall be superseded by subsequent updates posted by DHCS at:

https://www.dhcs.ca.gov/services/MH/Pages/medicalbehavioral-health-fee-schedulesmain.aspx.

Program 789 (LMN567P)

Contractor:

	Pr	ovider	Provider		
Provider Type	Ra	tes by	Rates by		
Flovider Type	М	inute	Minute		
	Ind	ividual	G	roup	
Certified AOD Counselor	\$	-			
Clinical Nurse Specialist	\$	8.11	\$	1.80	
Community Health Worker	\$	-			
LCSW/LPHA (Licensed, Waivered or Registered)	\$	4.24	\$	0.94	
Licensed Physician/Psychiatrist	\$	16.31	\$	3.62	
Licensed Psychiatric Technician	\$	2.98	\$	0.66	
Licensed Vocational Nurse	\$	3.48	\$	0.77	
MFT/LPCC (Licensed, Waivered or Registered)	\$	4.24	\$	0.94	
Medical Assistant	\$	2.39			
Mental Health Rehabilitation Specialist	\$	3.19			
Nurse Practitioner	\$	8.11	\$	1.80	
Occupational Therapist	\$	5.65	\$		
Other Qualified Practitioner	\$	3.19		0.66	
Peer Recovery/Support Specialist	\$	-	\$	-	
Physician Assistant	\$	7.31	\$	1.63	
Psychologist (Licensed or Waivered)	\$	6.56	\$	1.46	
Registered Nurse	\$	6.62	\$	1.47	
Registered Pharmacist	\$	7.81	\$	1.73	

|--|

Interactive Complexity (All Types)

\$18.89

ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMI	ENT
BEHAVIORAL HEALTH PROGRAMS	
PROVIDER CLAIM / SERVICE REPORT	

Provider Name:	Program 789 Non-Profit Compan	у	Provider's Claim I	Number: <u>7312025</u>
Type of Contract (Master or SAN):	SAN	Month/Year of Se	ervice: Jul-25
Remittance Addres	ss:		Check One:	
21 Jump Street			Original Subn	nission X
Oakland CA, 94601			_ Revised Subr	mission
Billing Contact Name:	Roger Rabbit		Phone Number:	510-222-2222
E-Mail:	Rabbit101@gmail.com		FAX Number:	510-444-4444

	PROGRAM NAME:		Program 7	'89						
	PROGRAM NUMBER:		(LMN567)	P)						
Practitio		Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Rehabilitation Sp	ecialist		3.19	0.00		3.19	0.00		3.19	0.00
Other Qualified Practitioner			3.19	0.00		3.19	0.00		3.19	0.0
Other Qualified Practitioner-Gro	oup		0.66	0.00		0.66	0.00		0.66	0.0
Social Worker (Licensed, Waive	ered, or Registered)		4.24	0.00		4.24	0.00		4.24	0.0
		~		0.00		0.00	0.00		0.00	0.0
				0.00		0.00	0.00		0.00	0.0
	Due stitie sees	T		0.00		0.00	0.00		0.00	0.00
	Practitioner	туре	•	0.00		0.00	0.00		0.00	0.0
				0.00		0.00	0.00		0.00	0.0
	Select Practit	ioner	-	0.00		0.00	0.00		0.00	0.0
				0.00		0.00	0.00		0.00	0.0
Supplemental Falt Rate - Intera	Type			0.00		0.00	0.00		0.00	0.0
Sign Language or Oral Interpre	ТУРС			0.00		0.00	0.00		0.00	0.0
Client Support Services (MHS/				0.00			0.00			0.0
Total Services - Actual Cost Pr					ADOTE			ADOTE		
Client Support Expenditures - 🗷	icidal Cost									
MHSA One-Time Expenses - Ac	tual Cost									
Measure A Non-Medi-Cal Eligible	le Expenses - Actual Cost									
Outreach & Engagement (includ	ding MAA) - Actual Cost									
24 Hour Care				0.00			0.00			0.0
Day Treatment				0.00			0.00			0.0
Other (must be specifically auth	norized in contract)									
TOTAL GROSS CLAIM				0.00			0.00]		0.00
LESS REVENUE:										
MEDICARE					I			1		
OTHER HEALTH COVERAGE								i		
OTHER REVENUE								i		
TOTAL REVENUE DEDUCTED				0.00			0.00			0.00
NET PROGRAM CLAIM				0.00			0.00]		0.0
Note: Use Claim-Page 2 if contract	has more than three programs.						Total Net Pro		c	

laim-Page 2 if contract has more than three programs,	Total Net Program Claim: (Total of All Pages)	_
	Less Cash Advance Reimbursement:	
	Payment Due:	_

hereby attest that the information	n contained in this document accurately	and truthfully reflects the costs inc	curred and revenue generated in the	e performance of th
as stated in the contract against :	which this claim is being made.			

Authorized Signature:	(must match CBO Signature Authorization form on file with ACBHD)	Date:	
Printed Name:		Title:	



Page __1__ of __X__

Provider Claim/Service Report (Invoice) Template and instructions

								Page _	_1 ofX
	BEHAVIO	RAL HE	IAVIORAL H ALTH PROG SERVICE I	GRAMS		TMENT			
Provider Name: Program 789 Non-Profit Company		CLAIN	SERVICE	KEFOK		's Claim Nun	ıber:	7312025	
Type of Contract (Master or SAN):	SAN				Month/Y	ear of Servi	e:	Jul-25	
Remittance Address:					Check O	ne.			
21 Jump Street						inal Submiss	ion	×	
Oakland CA, 94601					_	sed Submiss			
Billing Contact Name: Roger Rabbit					Phone Nun	mber:	510-222-2	222	
E-Mail: Rabbit101@gmail.com					FAX Numb	er:	510-444-4	444	
PROGRAM NAME:		Program 7	20						
PROGRAM NUMBER:		(LMN567)							
Practitioner Processing Nombers	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Rehabilitation Specialist	135.00	3.19	430.65		3.19	0.00		3.19	0.00
Other Qualified Practitioner Other Qualified Practitioner-Group	60.00 315.00	3.19 0.66	191.40 207.90		3.19 0.66	0.00	_	3.19 0.66	0.00
Social Worker (Licensed, Waivered, or Registered)	60.00	4.24	254.40		4.24	0.00		4.24	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00		0.00	0.00
Supplemental Falt Rate - Interactive complexity			0.00		0.00	0.00		0.00	0.00
Sign Language or Oral Interpretive Services			0.00		0.00	0.00		0.00	0.00
Client Support Services [MHSA or Adult Service Team] Total Services - Actual Cost Programs Only	LIST BORES		0.00	LIST BORRS		0.00	LIST HORRS		0.00
Client Support Expenditures - Actual Cost	ADOTE			40475			40446		
MHSA One-Time Expenses - Actual Cost									
Measure A Non-Medi-Cal Eligible Expenses - Actual Cost									
Outreach & Engagement (including MAA) - Actual Cost 24 Hour Care			0.00			0.00	_		0.00
Day Treatment			0.00			0.00			0.00
Other (must be specifically authorized in contract)									
TOTAL GROSS CLAIM		1	1,084.35			0.00			0.00
LESS REVENUE:							1		
MEDICARE OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM		ļ	1,084.35			0.00			0.00
Note: Use Claim-Page 2 if contract has more than three programs						Total Net Pro		n:	1,084.35
						Less Cash Ad	Ivance Rei	mburseme	nt:
						Payment Due:			1,084.35
I hereby attest that the information contained in this docume as stated in the contract against which this claim is being n		ely and trut	hfully reflects	the costs	incurred a	and revenue g	enerated i	n the perfo	rmance of the
Authorized Signature:						-	Date:		
(must match CBO Sign	nature Auth	orization f	orm on file wit	in ALBHD	'				
Printed Name:						-	Title:		
									Rev. 6/26/25



Run Date: August 21, 2025 03:13 Created By: Shukura Reynolds

Invoice Report By Practitioner

July 01, 2025, through July 31, 2025

Program 789 (LMN567P)

Practitioner	Procedure Code ID	Procedure Code Name	Time(hours)	Travel Time	Documentation Time	Units	Billable Minutes	Service Count
Mental Health Rehab	33	H2017 Psychosocial Rehab	2.27	0.00	0.28	9	135	3
Specialist		Mental Health Rehab Specialist Total	2.27	0.00	0.28	9	135	3
Other Qualified Practitioner	33	H2017 Psychosocial Rehab	0.99	0.00	0.25	4	60	2
		Other Qualified Practitioner Total	0.99	0.00	0.25	4	60	2
Other Qualified Practitioner	523	H2017 Group Psychosocial Rehab	5.17	0.00	0.66	21	315	5
Group		Other Qualified Practitioner Group Total	5.17	0.00	0.66	21	315	5
Social Worker	48	T1017 Targeted Case Mgmt (TCM)	0.60	0.00	0.13	2	30	1
	879	90832, 90834 & 90837 Psychotherapy, w/Patient (w/T2021 Sub-Code)	1.21	0.00	0.43	1	30	3
		Social Worker Total	1.81	0.00	0.56	3	60	4
Total			10.24	0.00	1.75	37	570	14
		mil						

This report is based on "Completed" Services only as of run date

If the program is **rate based**, enter the "**Billable Minutes**" and the claim form will calculate the total amount in the Gross Claim column.

Department

Provider Claim/Service Report (Invoice) Template and instructions

A	В	C	D	E	F	G	Н		J	K L	
									Page _	_1 ofX	
	ALAMEDA COUN	TY HEAL	TH BEH	AVIORAL E	IEAI TH	DEPART	MENT				
				ALTH PRO		DEI AIT					
				SERVICE		-					
		CVIDEI	CLAIM	SERVICE	KLI OK	•					
Provider Name: Program 789 N	Non-Profit Company					Provider	's Claim Num	ber:	7312025		
Type of Contract (Master or SAN):		SAN				Month/Year of Service: Jul-25					
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,											
Remittance Address:						Check O	ne:				
21 Jump Street						Origi	nal Submiss	ion	X		
						•					
Oakland CA, 94601						Revi	sed Submiss	sion .			
Billing Contact Name: Roger Rabbit						Phone Nun	nber:	510-222-22	22		
E-Mail: Rabbit101@gmail.com	0					FAX Number	er:	510-444-44	44		
	PROGRAM W			00							
	PROGRAM NAME:		Program 7	89							
	PROGRAM NUMBER:		(LMN567								
Practitioner		Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim	
Mental Health Rehabilitation Specialist		135.00	3.19	430.65		3.19	0.00	\vdash	3.19	0.00	
Other Qualified Practitioner		60.00	3.19	191.40		3.19	0.00		3.19	0.00	
Other Qualified Practitioner-Group		315.00	0.66	207.90		0.66	0.00		0.66	0.00	
Social Worker (Licensed, Waivered, or	Registered)	60.00	4.24	254.40		4.24	0.00	\vdash	4.24	0.00	
				0.00		0.00	0.00		0.00	0.00	
				0.00		0.00	0.00		0.00	0.00	
				0.00		0.00	0.00	$\overline{}$	0.00	0.00	
				0.00		0.00	0.00		0.00	0.00	
				0.00		0.00	0.00		0.00	0.00	
				0.00		0.00	0.00	\vdash	0.00	0.00	
Supplemental Falt Rate - Interactive co	mml nuitu		18.89	0.00		18.89	0.00		18.89	0.00	
Sign Language or Oral Interpretive Ser			10.05	0.00		0.00	0.00		0.00	0.00	
Client Support Services (MHSA or Adu				0.00		0.00	0.00		0.00	0.00	
Total Services - Actual Cost Programs		LIST BORES ADOTE		0.00	LIST BORES		0,00	LIST BORES ADOTE		0.00	
Client Support Expenditures - Actual C											
MHSA One-Time Expenses - Actual Co											
Measure A Non-Medi-Cal Eligible Expe											
Outreach & Engagement (including MA											
24 Hour Care	•			0.00			0.00			0.00	
Day Treatment				0.00			0.00			0.00	
Other (must be specifically authorized	in contract)										
								1			
TOTAL GROSS CLAIM				1,084.35			0.00	J	- 1	0.00	
LESS REVENUE:											
MEDICARE						1		1			
OTHER HEALTH COVERAGE								1			
OTHER REVENUE											
TOTAL REVENUE DEDUCTED				0.00			0.00			0.00	
NET PROGRAM CLAIM				1,084.35			0.00			0.00	
										_	
				1,00 1100							
	re than three programs.		,	1,00 1100			Total Net Pro	gram Claim	e 1	1,084.35	
	re than three programs.		'	1,001.00			Total Net Prog	gram Clain	r:	1,084.35	
	re than three programs.		,	1,00 1.00			Total Net Prog (Total of All Page Less Cash Ac	40)			
	re than three programs.		,	1,00 1100			(Total of All Page	40)			
	re than three programs.		!	1,00 1,00			(Total of All Page	40)			
	re than three programs.		!	1,00 1.00			(Total of All Page Less Cash Ac	40)		nt:	
Note: Use Claim.Page 2 if contract has mo	tained in this docume	nt accurate	ly and trul		: the costs		(Total of All Pagi Less Cash Ac Payment Due:	o) Ivance Rei	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo	tained in this docume	nt accurate	ly and trul		the costs		(Total of All Pagi Less Cash Ac Payment Due:	o) Ivance Rei	mburseme	nt: 1,084.35	
Note: Use Claim.Page 2 if contract has mo	tained in this docume	nt accurate	ly and trut		the costs		(Total of All Pagi Less Cash Ac Payment Due:	o) Ivance Rei	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo I hereby attest that the information contact against which	tained in this docume	nt accurate	ly and trut		the costs		(Total of All Pagi Less Cash Ac Payment Due: and revenue g	e) Ivance Rei enerated in	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo I hereby attest that the information coni as stated in the contract against which Authorized Signature:	tained in this docume	nt accurate ade.		hfully reflects		incurred a	(Total of All Pagi Less Cash Ac Payment Due: and revenue g	o) Ivance Rei	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo I hereby attest that the information coni as stated in the contract against which Authorized Signature:	tained in this docume this claim is being m	nt accurate ade.		hfully reflects		incurred a	(Total of All Pagi Less Cash Ac Payment Due: and revenue g	e) Ivance Rei enerated in	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo I hereby attest that the information coni as stated in the contract against which Authorized Signature:	tained in this docume this claim is being m	nt accurate ade.		hfully reflects		incurred a	(Total of All Pagi Less Cash Ac Payment Due: and revenue g	e) Ivance Rei enerated in	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo I hereby altest that the information con as stated in the contract against which Authorized Signature:	tained in this docume this claim is being m	nt accurate ade.		hfully reflects		incurred a	(Total of All Pagi Less Cash Ac Payment Due: and revenue g	e) Ivance Rei enerated in	mburseme	nt: 1,084.35	
Note: Use Claim-Page 2 if contract has mo I hereby attest that the information coni as stated in the contract against which Authorized Signature:	tained in this docume this claim is being m	nt accurate ade.		hfully reflects		incurred a	(Total of All Pagi Less Cash Ac Payment Due: and revenue g	dvance Reidenerated in	mburseme	nt: 1,084.35	

If the "reimbursement method" is "actual cost," list the total actual costs for the month on the applicable line of the claim form.



Provider Claim/Service Report (Invoice) Template and

instructions

n B	C			F		П		Page _	1_ of _X_
	BEHAVIO	RAL HEA	AVIORAL I ALTH PRO SERVICE	GRAMS		MENT			
Provider Name: Program 789 Non-Profit Company	,				Provider	's Claim Nur	nber:	7312025	
Type of Contract (Master or SAN): SAN				Month/Year of Service:			ce:	Jul-25	
Remittance Address:					Check O	ne:			
21 Jump Street						nal Submiss	sion	x	
Oakland CA, 94601					Revi	sed Submis	sion		
Billing Contact Name: Roger Rabbit					Phone Nun	nber:	510-222-22	222	
E-Mail: <u>Rabbit/Di@gmail.com</u>				FAX Number:			510-444-4444		
PROGRAM NAME:		Program 7	90						
PROGRAM NUMBER:		(LMN567F							
Practitioner Proofform Hombert.	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Rehabilitation Specialist	135.00	3.19	430.65		3.19	0.00		3.19	0.00
Other Qualified Practitioner Other Qualified Practitioner-Group	60.00 315.00	3.19 0.66	191.40 207.90		3.19 0.66	0.00		3.19 0.66	0.00
Social Worker (Licensed, Waivered, or Registered)	60.00	4.24	254.40		4.24	0.00		4.24	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00	-	0.00	0.00
			0.00		0.00	0.00	-	0.00	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00		0.00	0.00
			0.00		0.00	0.00		0.00	0.00
Supplemental Falt Rate - Interactive complexity Sign Language or Oral Interpretive Services		18.89	0.00		18.89	0.00	-	18.89 0.00	0.00
Client Support Services (MHSA or Adult Service Team)			0.00		0.00	0.00		0.00	0.00
Total Services - Actual Cost Programs Only	LIST HORRS ADOTE			LIST HORRS ADOTE			LIST BARRS ADATE		
Client Support Expenditures - Actual Cost									
MHSA One-Time Expenses - Actual Cost Measure A Non-Medi-Cal Eligible Expenses - Actual Cost									
Outreach & Engagement (including MAA) - Actual Cost									
24 Hour Care			0.00			0.00			0.00
Day Treatment			0.00			0.00			0.00
Other (must be specifically authorized in contract)									
TOTAL GROSS CLAIM			1,084.35			0.00]		0.00
LESS REVENUE:		Г		1			1	г	
MEDICARE OTHER HEALTH COVERAGE		ŀ					1	H	
OTHER REVENUE		İ		İ			1	F	
TOTAL REVENUE DEDUCTED		[0.00			0.00]		0.00
NET PROGRAM CLAIM		[1,084.35]		0.00]		0.00
Note: Use Claim-Page 2 if contract has more than three programs						Total Net Pro	gram Clain	n:	1,084.35
						Less Cash A		mburseme <u>r</u>	ıt:
						Payment Due:			1,084.35
I hereby attest that the information contained in this docume as stated in the contract against which this claim is being m	nt accurate ade.	ly and trut	hfully reflect	s the costs	s incurred a	and revenue <u>c</u>	jenerated ii	n the perfor	mance of the
Authorized Signature:							Date:		
(must match CBO Sign	ature Auth	orization fo	orm on file wi	th ACBHD)]				
Printed Name:							Title:		
									Rev. 6/26/25



Submit Claims to Accounts Payable (AP) - ACBHD

- Reminder This is a restructured process between:
 - Accounts Payable (AP) ACBHD
 - Disbursement Division Alameda County Auditor Controller's office

Submit claims/questions to the AP Unit at:

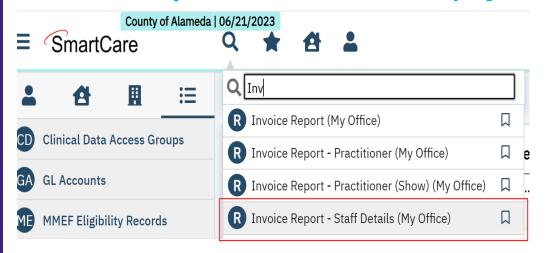
CBOPayment@acgov.org

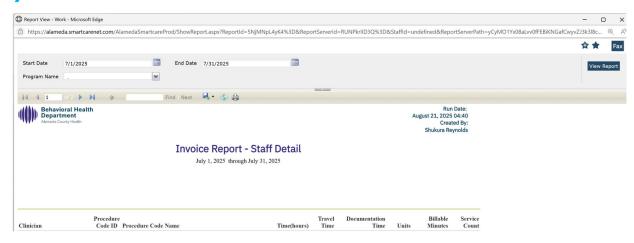
- Always copy your fiscal contract manager
- CalWORKS/Grant program invoices due 10 Days after end of service month, or by earlier Grant deadline if communicated by ACBHD
- Templates, we will follow up with a communication around how to receive Provider Claim templates.
- Current insurance on file; Exhibit C must be current, or there will be an issue getting your voucher processed.



Reconciling SmartCare Service Data

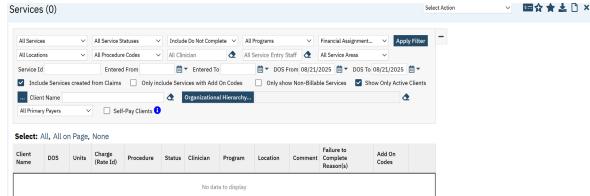
Invoice Report - Staff Details (My Office)





Services (My Office) - List Page







System Update – SmartCare Service Entry Reminder

- Smart Care Service Entry
 - FY 24-25 deadlines
 - FY 25-26 Standard deadlines

Service Month	Service Data Entry Due Date		
July 2025	August 31, 2025		
August 2025	September 30, 2025		
September 2025	October 31, 2025		
October 2025	November 30, 2025		
November 2025	December 31, 2025		
December 2025	January 31, 2026		
January 2026	February 28, 2026		
February 2026	March 31, 2026		
March 2026	April 30, 2026		
April 2026	May 31, 2026		
May 2026	June 30, 2026		
June 2026	July 31, 2026		

Service Month	Service Data Entry Due Date		
July 2024	January 17, 2025		
August 2024	February 7, 2025		
September 2024	February 28, 2025		
October 2024	March 21, 2025		
November 2024	April 11, 2025		
December 2024	May 2, 2025		
January 2025	May 23, 2025		
February 2025	June 6, 2025		
March 2025	June 20, 2025		
April 2025	July 4, 2025		
May 2025	July 18, 2025		
June 2025	August 1, 2025		



Service Errors and Warnings

SmartCare System Setup Requirements for Successful Service Entry

To ensure successful Service Entry in SmartCare, the below factors and requirements should be validated before you begin to record services. These requirements include:

- Programs (previously known as Reporting Units) must be set up in SmartCare.
- Procedures codes must be setup in SmartCare.
 - The Clinical Staff license/degree (previously known as discipline) will determine what procedure codes can be selected.
- SmartCare Staff Accounts
 - The clinical staff providing the services must have a SmartCare staff account, with appropriate permissions and be linked to the program.
 - The data entry staff entering the services must have a SmartCare staff account and be linked to the program.
 - Clinical Staff must have the correct license/degree for service entry in SmartCare.
 NOTE: Staffing license/degree changes for successful service entry can be reported via the Staff E-form.
- Client Registration and Program Enrollment (formerly known as episodes)
 - Clients must be Registered and Enrolled (formerly known as opening an episode) in the Program(s) you are entering services for.
 - **NOTE:** For program updates and/or changes please contact the HIS Support desk for assistance.
 - Clients must have a SmartCare Diagnosis document on file within the program enrollment period updated with the diagnosis information as it pertains to the service provided.



Service Errors and Warnings

- Review the Services (My office) list page daily and address services in error status.
- Common Provider errors
 - Billing Diagnosis
 - Unable to find matching rate
 - Authorization required
- Ensure your SmartCare staff information is up to date.
- Completing E-forms with accuracy and completeness.

Common Service Entry Validation Errors

Here are some frequently encountered validation errors during Service Entry and Completion Processing:

Error Type ID	Service Completion Error and Warning Messages
4401	This procedure requires a clinician to be specified for the service.
4403	Unable to find a matching rate for the selected procedure.
4404	Billing diagnosis required for completing the service
4406	Authorization is required
4407	Auth requested but not approved
4410	Financial information has not been completed for this client.
4411	Duration does not match DateTime In/DateTime Out.
4412	End Date does not equal Start Date.
4413	Duration cannot be negative.
4414	Service Date/Time does not match Time In/Time Out.
11127444	Please enter valid Start Time
11127445	Please enter valid Duration
11127446	Please enter valid End Time
11134507	Pregnancy Indicator is required
11134508	Pregnancy Indicator does not match the value set on the Claim.
11134509	Emergency Indicator cannot be set as "No"
11136057	Pregnancy Indicator cannot be set as "No" or "N/A"



Questions & Answers





ACBHD Tools and Resources

- Provider Website: Home, News | ACBH Providers Website (acbhcs.org)
 - SmartCare | ACBD Providers Website
 - o **QA Manual**
 - Staff E-forms for SmartCare and Invoice Report Access
 - o QA Memos and Notices
 - o DHCS MedCCC Library



Provider Questions: Other Resources

Responses to Questions and Invoice Report Support

- Presentation and handouts will also be posted online
- MH Office Hours

MH Office Hours Monday & Wednesday - 3:00pm - 4:00pm NOTE: Given the demand for SC MHS Office Hours, we will be reducing the sessions to twice a week. Please click the attached link to join the call. Click here to join the meeting Meeting ID: 231 302 352 240 Passcode: Pq5sjp Download Teams| Join on the web Or call in (audio only) +1 415-915-3950,,334618237# United States, San Francisco (888) 715-8170,,334618237# United States (Toll-free)

ACBHD Help Desk: <u>HCSASupport@acgov.org</u>

Help Desk Phone #: (510) 567-8181

M – F: 8:30 am to 5:00 pm

FAX #: (510) 567-8161





