Alameda County Health, Behavioral Health Department (ACBHD)

SmartCare Invoice Report Training

August 21, 2025

Behavioral Health Department
Alameda County Health

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.

Behavioral Health Department
Alameda County Health

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.

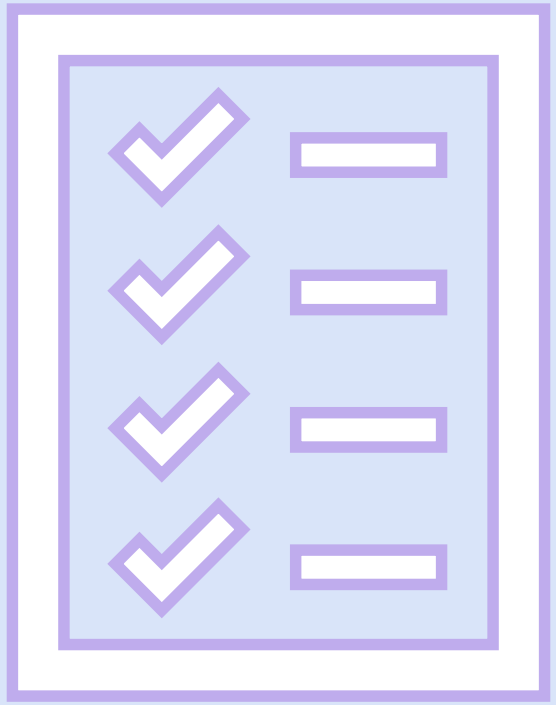
Invoice Report by Practitioner

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

Behavioral Health Department
Alameda County Health

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**



Behavioral Health Department
Alameda County Health

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

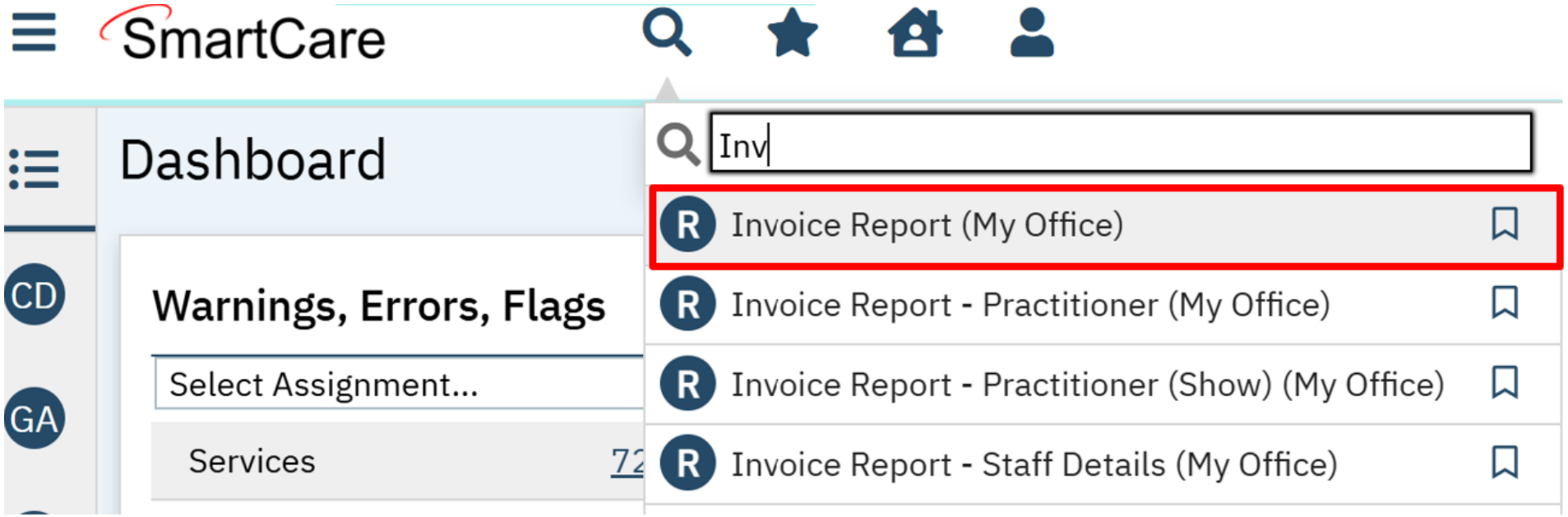
Service Type / Description	Unit	Reimbursement Method	Rate
Outpatient Services			
Case Management	Per Hour	Provisional Rate	$200.00
Mental Health Services	Per Hour	Provisional Rate	$100.00
Crisis Intervention	Per Hour	Provisional Rate	$300.00
Medication Support	Per Hour	Provisional Rate	$400.00
Interactive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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

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
    - **NOTE:** By typing the first three characters, the drop-down list will begin to populate
- Select the report titled **“Invoice Report (My Office)”**

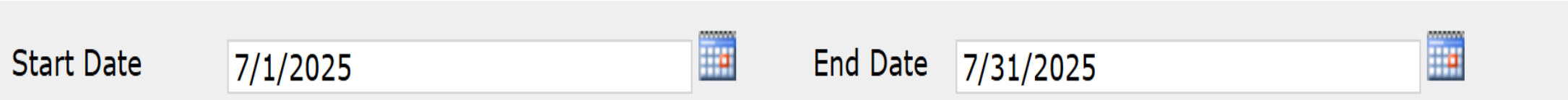


Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

Generating SmartCare Invoice Report

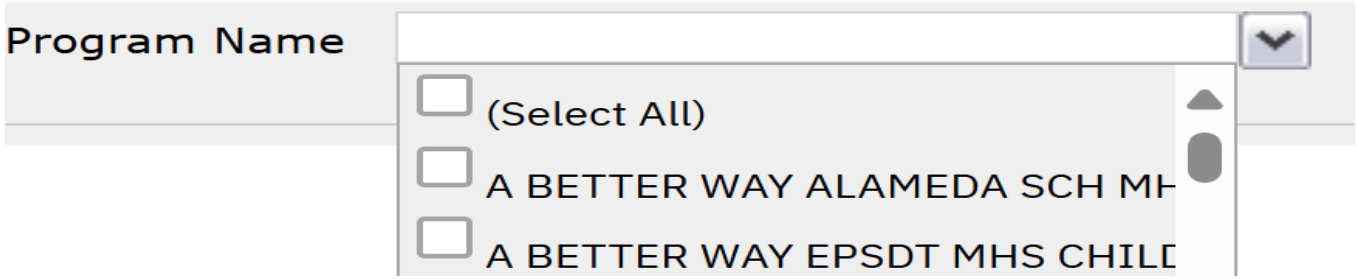
- The report pop-up box will populate in a new window
- Complete the report filters.
  - Add Start and End date.
    - For monthly Provider Claims, the date range should be for the entire service month.
      - Example, for the service period July 2025, the start and end dates will be 07/01/2025-07/31/2025.



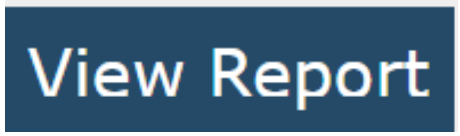
Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

- **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



Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

Generating SmartCare Invoice Report

Behavioral Health Department
Alameda County Health

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 Time	Documentation 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.

Invoicing for Treatment Programs (Legacy)

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

Invoicing for Treatment Programs (Legacy)

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

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
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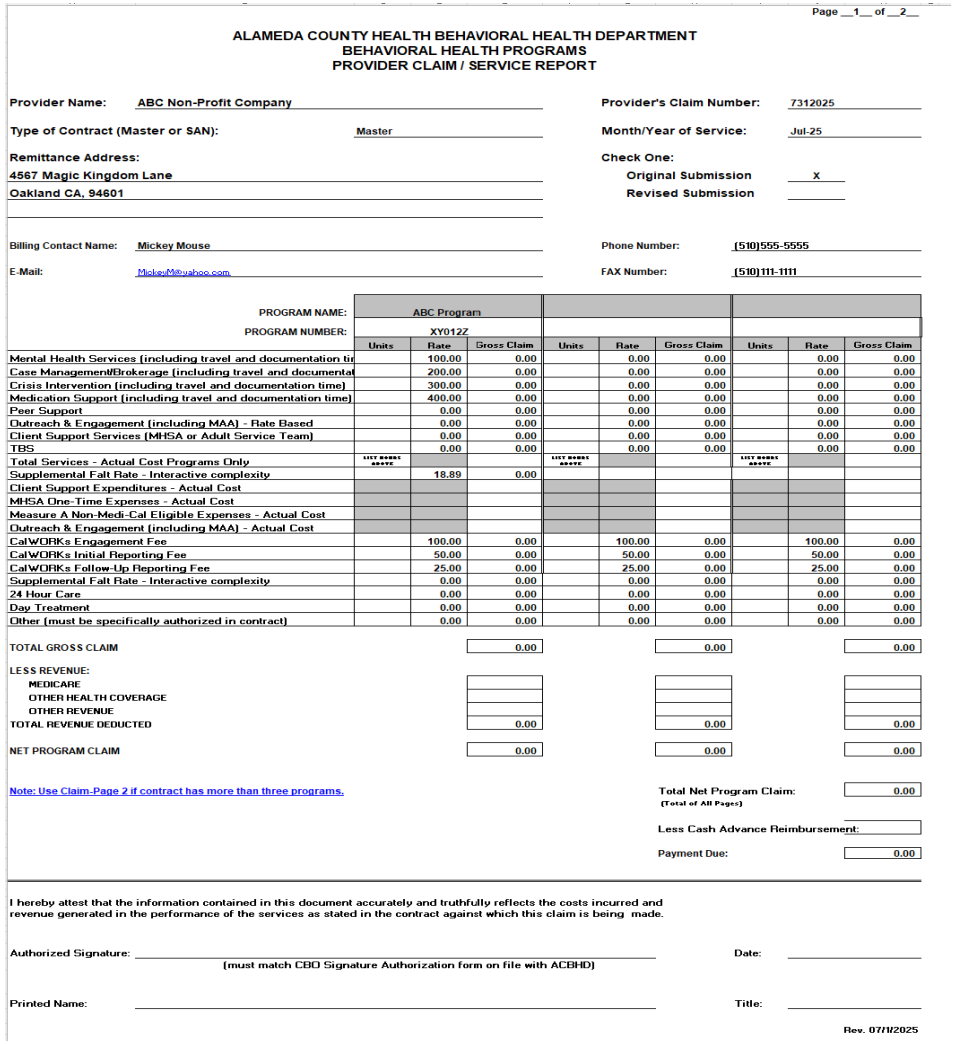
Medication Support	Per Hour	Provisional Rate	$400.00
Interactive Complexity	Per Occurrence	Negotiated Rate	$18.89
Other Services/ Expenditures			
Other Services/ Expenditures	N/A	Actual Cost	N/A



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: 7312025
Type of Contract (Master or SAN): Master
Month/Year of Service: Jul-25
Remittance Address:
4567 Magic Kingdom Lane
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission

Billing Contact Name: Mickey Mouse
Phone Number: (510)555-5555
E-Mail: MickeyM@yahoo.com
FAX Number: (510)111-1111

PROGRAM NAME:	ABC Program								
PROGRAM NUMBER:	XY012Z								
	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Services (including travel and documentation ti		100.00	0.00		0.00	0.00		0.00	0.00
Case Management/Brokerage (including travel and documentat		200.00	0.00		0.00	0.00		0.00	0.00
Crisis Intervention (including travel and documentation time)		300.00	0.00		0.00	0.00		0.00	0.00
Medication Support (including travel and documentation time)		400.00	0.00		0.00	0.00		0.00	0.00
Peer Support		0.00	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	0.00
Client Support Services (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
TBS		0.00	0.00		0.00	0.00		0.00	0.00
Total Services - Actual Cost Programs Only	LIST BOXES ABOVE			LIST BOXES ABOVE			LIST BOXES ABOVE		
Supplemental Falt Rate - Interactive complexity		18.89	0.00						
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		100.00	0.00		100.00	0.00		100.00	0.00
CalWORKs Initial Reporting Fee		50.00	0.00		50.00	0.00		50.00	0.00
CalWORKs Follow-Up Reporting Fee		25.00	0.00		25.00	0.00		25.00	0.00
Supplemental Falt Rate - Interactive complexity		0.00	0.00		0.00	0.00		0.00	0.00
24 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 specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
TOTAL GROSS CLAIM			0.00			0.00			0.00
LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM			0.00			0.00			0.00

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

Total Net Program Claim: 0.00
(Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due: 0.00

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: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

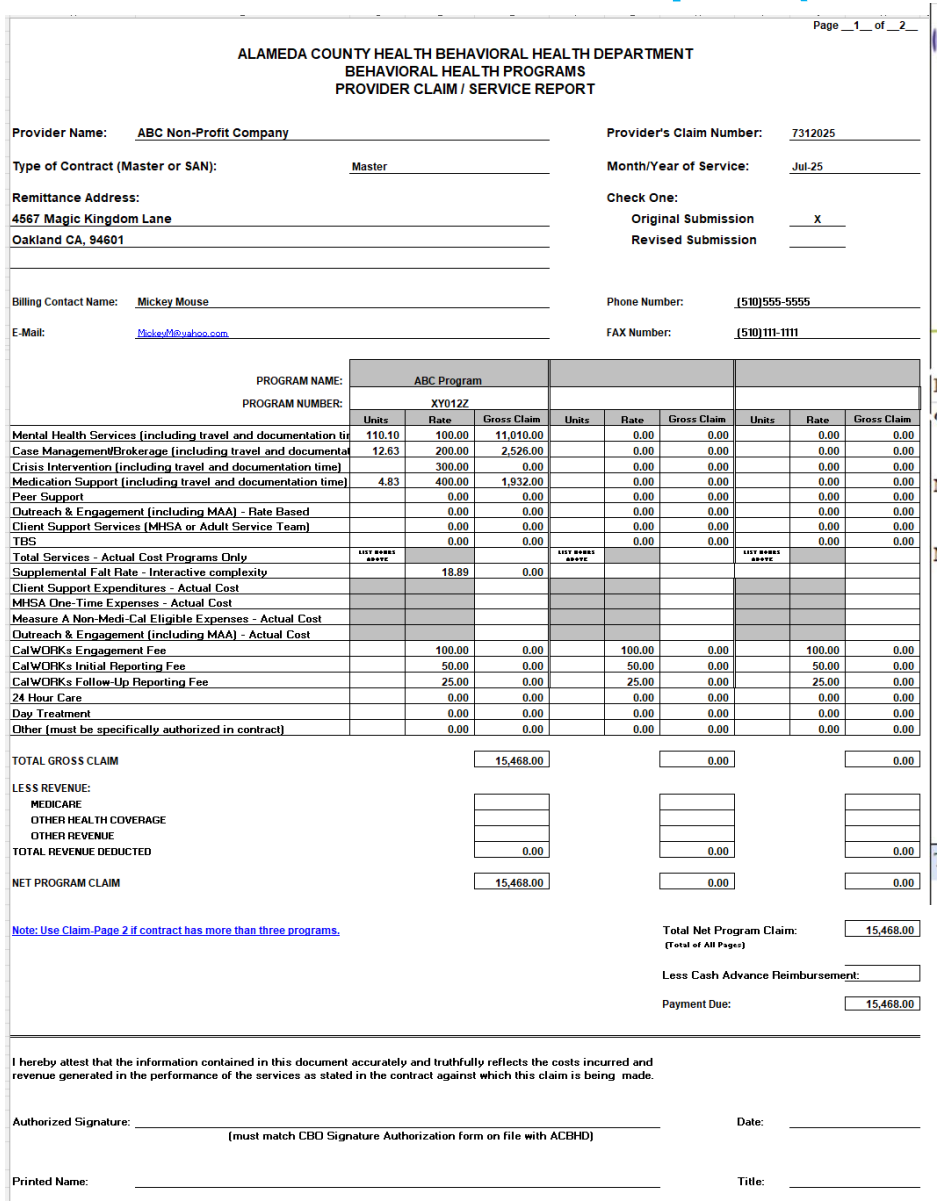
Printed Name: _____ Title: _____

Rev. 07/1/2025

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

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: 7312025
Type of Contract (Master or SAN): Master
Month/Year of Service: Jul-25
Remittance Address:
4567 Magic Kingdom Lane
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission
Billing Contact Name: Mickey Mouse
Phone Number: (510)555-5555
E-Mail: MickeyM@yahoo.com
FAX Number: (510)111-1111

PROGRAM NAME:	ABC Program								
PROGRAM NUMBER:	XY012Z								
	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Services (including travel and documentation tir	110.10	100.00	11,010.00		0.00	0.00		0.00	0.00
Case Management/Brokerage (including travel and documentat	12.63	200.00	2,526.00		0.00	0.00		0.00	0.00
Crisis Intervention (including travel and documentation time)		300.00	0.00		0.00	0.00		0.00	0.00
Medication Support (including travel and documentation time)	4.83	400.00	1,932.00		0.00	0.00		0.00	0.00
Peer Support		0.00	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	0.00
Client Support Services (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
TBS		0.00	0.00		0.00	0.00		0.00	0.00
Total Services - Actual Cost Programs Only	LIST BOXES ABOVE			LIST BOXES ABOVE			LIST BOXES ABOVE		
Supplemental Fall Rate - Interactive complexity		18.89	0.00						
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		100.00	0.00		100.00	0.00		100.00	0.00
CalWORKs Initial Reporting Fee		50.00	0.00		50.00	0.00		50.00	0.00
CalWORKs Follow-Up Reporting Fee		25.00	0.00		25.00	0.00		25.00	0.00
24 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 specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
TOTAL GROSS CLAIM			15,468.00			0.00			0.00
LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM			15,468.00			0.00			0.00

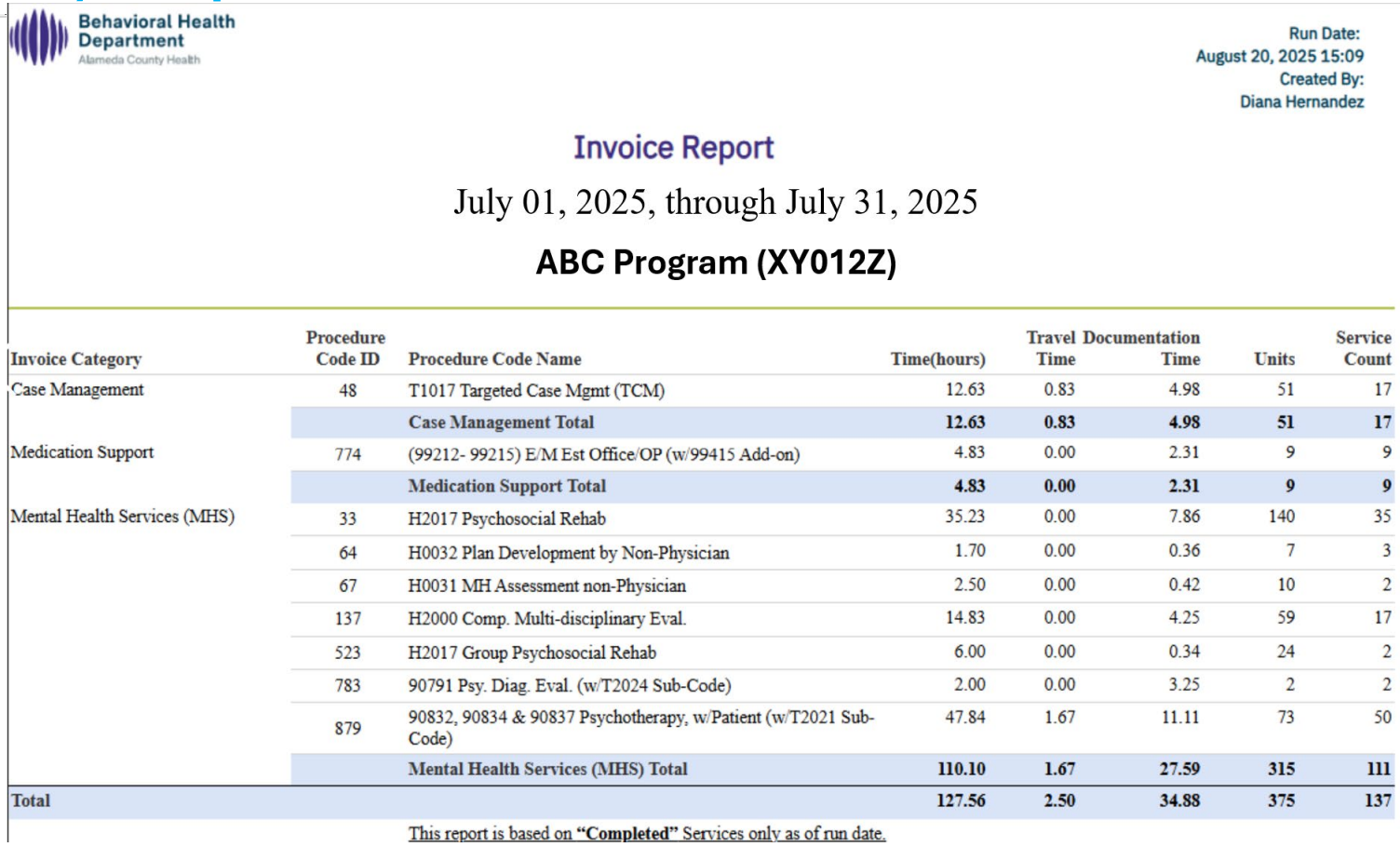
Note: Use Claim-Page 2 if contract has more than three programs.

Total Net Program Claim: 15,468.00
(Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due: 15,468.00

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: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

Printed Name: _____ Title: _____



Behavioral Health Department
Alameda County Health

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 Time	Documentation 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**

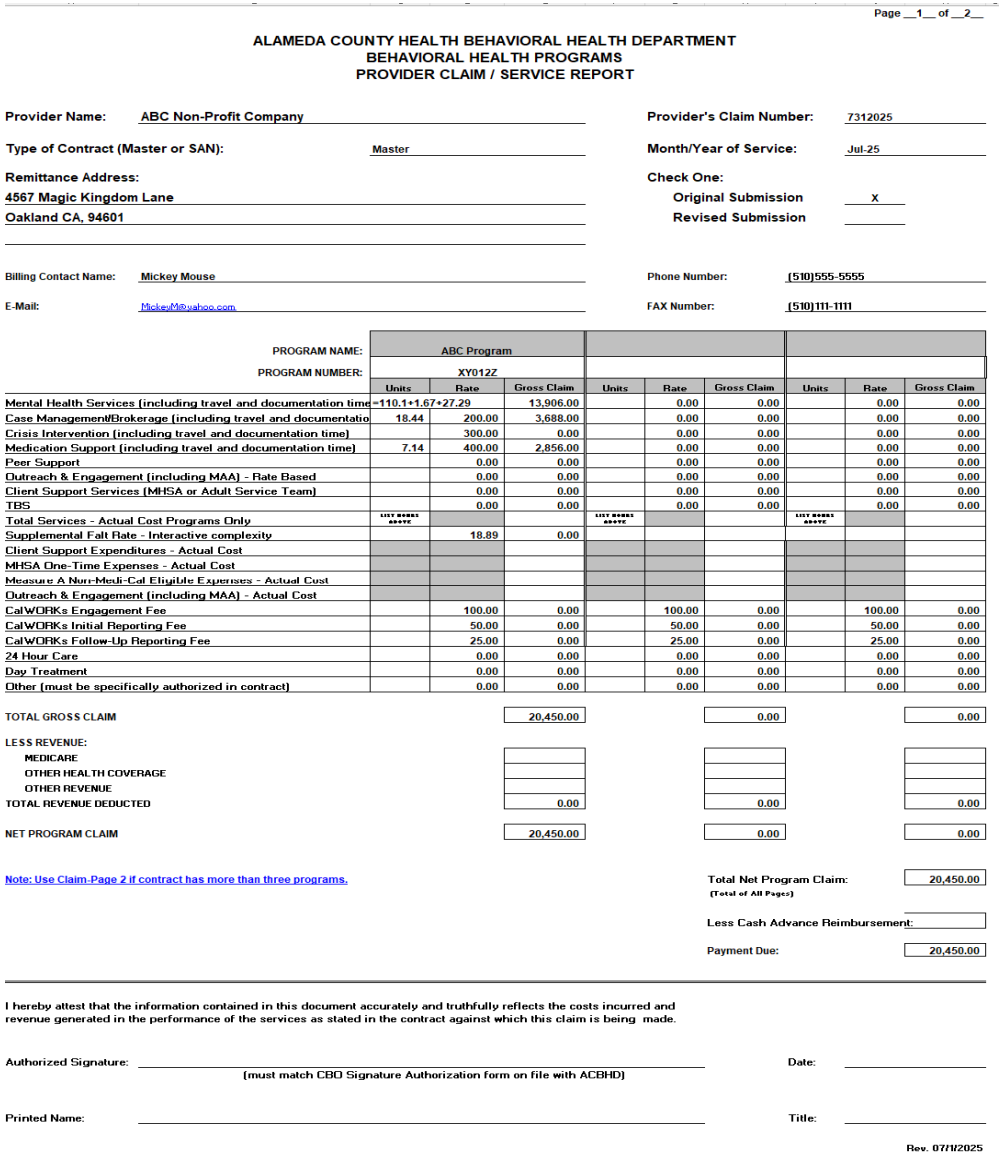
This report is based on **"Completed"** Services only as of run date.

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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

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: 7312025
Type of Contract (Master or SAN): Master
Month/Year of Service: Jul-25
Remittance Address:
4567 Magic Kingdom Lane
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission

Billing Contact Name: Mickey Mouse
Phone Number: (510)555-5555
E-Mail: MickeyM@yahoo.com
FAX Number: (510)111-1111

PROGRAM NAME:	ABC Program								
PROGRAM NUMBER:	XY012Z								
	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Services (including travel and documentation time	=110.1+1.67+27.29		13,906.00		0.00	0.00		0.00	0.00
Case Management/Brokerage (including travel and documentatio	18.44	200.00	3,688.00		0.00	0.00		0.00	0.00
Crisis Intervention (including travel and documentation time)		300.00	0.00		0.00	0.00		0.00	0.00
Medication Support (including travel and documentation time)	7.14	400.00	2,856.00		0.00	0.00		0.00	0.00
Peer Support		0.00	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	0.00
Client Support Services (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
TBS		0.00	0.00		0.00	0.00		0.00	0.00
Total Services - Actual Cost Programs Only	LIST HERE ABOVE			LIST HERE ABOVE			LIST HERE ABOVE		
Supplemental Falt Rate - Interactive complexity		18.89	0.00						
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		100.00	0.00		100.00	0.00		100.00	0.00
CalWORKs Initial Reporting Fee		50.00	0.00		50.00	0.00		50.00	0.00
CalWORKs Follow-Up Reporting Fee		25.00	0.00		25.00	0.00		25.00	0.00
24 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 specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
TOTAL GROSS CLAIM			20,450.00			0.00			0.00
LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM			20,450.00			0.00			0.00

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

Total Net Program Claim: 20,450.00
(Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due: 20,450.00

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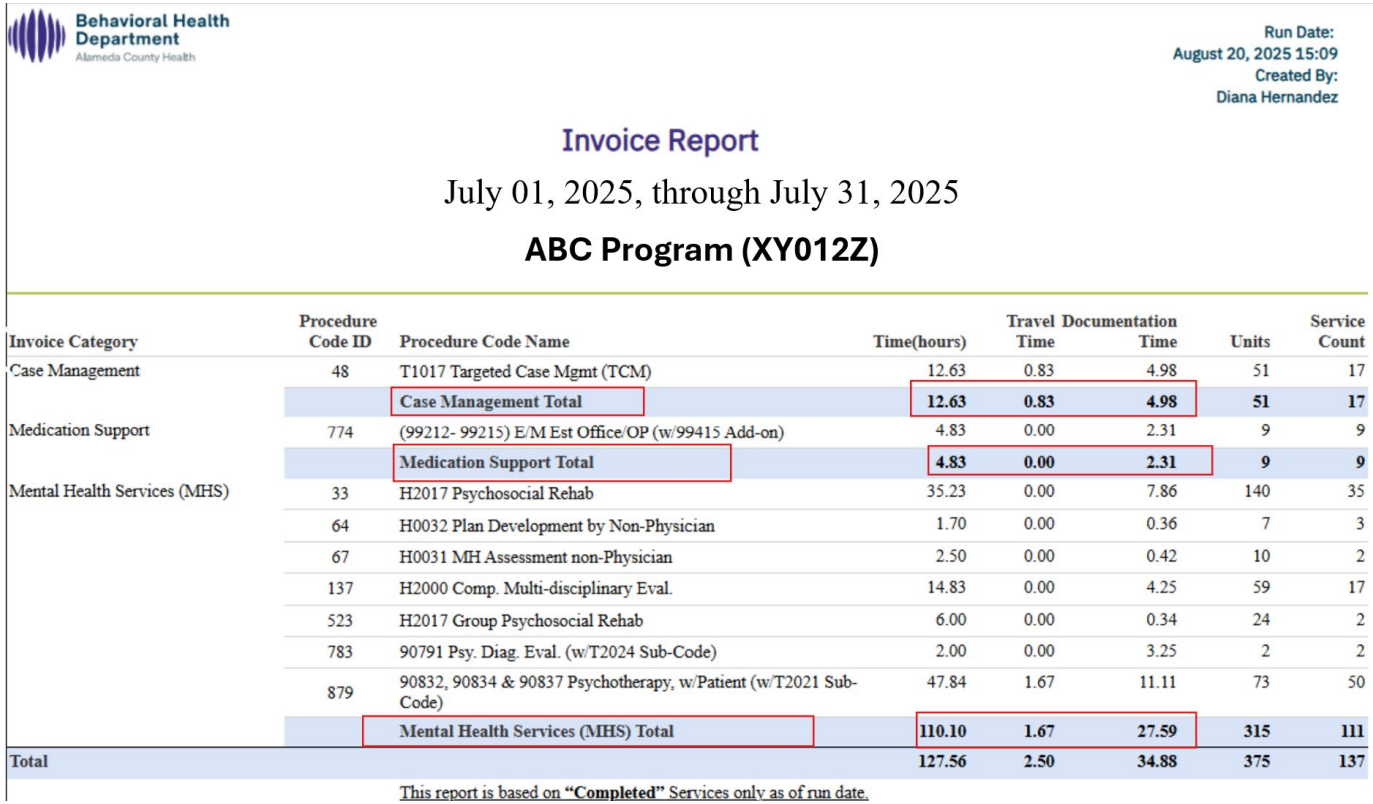
Authorized Signature: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

Printed Name: _____ Title: _____

Rev. 07/1/2025



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Alameda County Health

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		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**

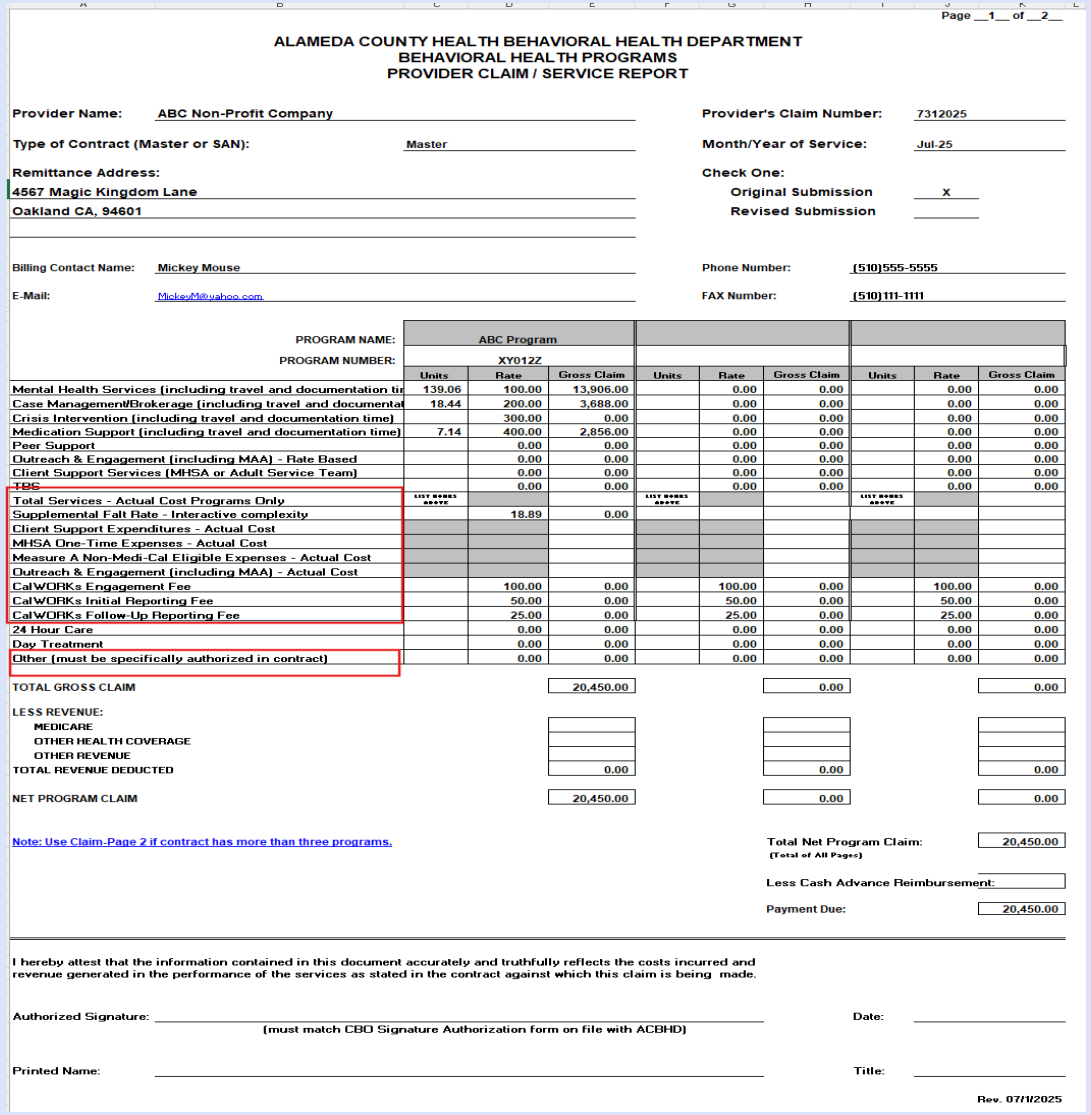
This report is based on **"Completed"** Services only as of run date.

Enter Travel Time and Documentation Time, when applicable.

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

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: 7312025
Type of Contract (Master or SAN): Master
Month/Year of Service: Jul-25
Remittance Address:
4567 Magic Kingdom Lane
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission

Billing Contact Name: Mickey Mouse
Phone Number: (510)555-5555
E-Mail: MickeyM@yahoo.com
FAX Number: (510)111-1111

PROGRAM NAME:	ABC Program								
PROGRAM NUMBER:	XY012Z								
	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Services (including travel and documentation tir	139.06	100.00	13,906.00		0.00	0.00		0.00	0.00
Case Management/Brokerage (including travel and documentat	18.44	200.00	3,688.00		0.00	0.00		0.00	0.00
Crisis Intervention (including travel and documentation time)		300.00	0.00		0.00	0.00		0.00	0.00
Medication Support (including travel and documentation time)	7.14	400.00	2,856.00		0.00	0.00		0.00	0.00
Peer Support		0.00	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	0.00
Client Support Services (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
~~TBS~~		0.00	0.00		0.00	0.00		0.00	0.00
Total Services - Actual Cost Programs Only	LIST HOURS ABOVE			LIST HOURS ABOVE			LIST HOURS ABOVE		
Supplemental Falt Rate - Interactive complexity		18.89	0.00						
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		100.00	0.00		100.00	0.00		100.00	0.00
CalWORKs Initial Reporting Fee		50.00	0.00		50.00	0.00		50.00	0.00
CalWORKs Follow-Up Reporting Fee		25.00	0.00		25.00	0.00		25.00	0.00
24 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 specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
TOTAL GROSS CLAIM			20,450.00			0.00			0.00
LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM			20,450.00			0.00			0.00

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

Total Net Program Claim: 20,450.00
(Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due: 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: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

Printed Name: _____ Title: _____

Rev. 07/1/2025

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

ABC Program (XY012Z)

FY 2025-2026

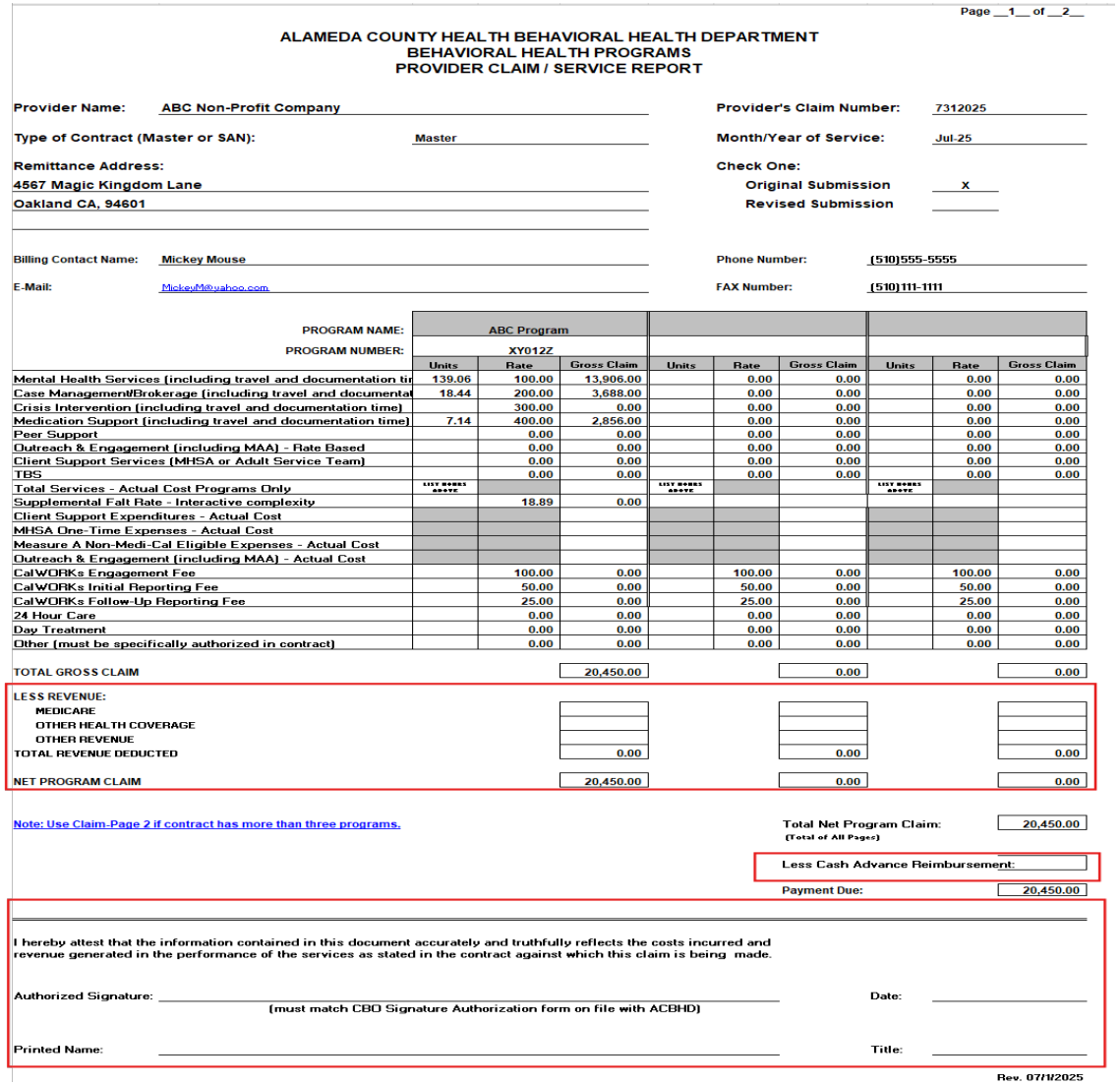
Service Type / Description	Unit	Reimbursement Method	Rate
Outpatient Services			
Case Management	Per Hour	Provisional Rate	$200.00
Mental Health Services	Per Hour	Provisional Rate	$100.00
Crisis Intervention	Per Hour	Provisional Rate	$300.00
Medication Support	Per Hour	Provisional Rate	$400.00
Interactive 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.

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

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: 7312025
Type of Contract (Master or SAN): Master
Month/Year of Service: Jul-25
Remittance Address:
4567 Magic Kingdom Lane
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission
Billing Contact Name: Mickey Mouse
Phone Number: (510)555-5555
E-Mail: MickeyM@yahoo.com
FAX Number: (510)111-1111

	PROGRAM NAME:	ABC Program							
	PROGRAM NUMBER:	XY012Z							
	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Services (including travel and documentation ti	139.06	100.00	13,906.00		0.00	0.00		0.00	0.00
Case Management/Brokerage (including travel and documentat	18.44	200.00	3,688.00		0.00	0.00		0.00	0.00
Crisis Intervention (including travel and documentation time)		300.00	0.00		0.00	0.00		0.00	0.00
Medication Support (including travel and documentation time)	7.14	400.00	2,856.00		0.00	0.00		0.00	0.00
Peer Support		0.00	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	0.00
Client Support Services (MHSA or Adult Service Team)		0.00	0.00		0.00	0.00		0.00	0.00
TBS		0.00	0.00		0.00	0.00		0.00	0.00
Total Services - Actual Cost Programs Only	LIST HOURS ABOVE			LIST HOURS ABOVE			LIST HOURS ABOVE		
Supplemental Falt Rate - Interactive complexity		18.89	0.00						
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		100.00	0.00		100.00	0.00		100.00	0.00
CalWORKs Initial Reporting Fee		50.00	0.00		50.00	0.00		50.00	0.00
CalWORKs Follow-Up Reporting Fee		25.00	0.00		25.00	0.00		25.00	0.00
24 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 specifically authorized in contract)		0.00	0.00		0.00	0.00		0.00	0.00
TOTAL GROSS CLAIM			20,450.00			0.00			0.00
LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM			20,450.00			0.00			0.00

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

Total Net Program Claim: 20,450.00
(Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due: 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: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

Printed Name: _____ Title: _____

Rev. 07/1/2025

Behavioral Health Department
Alameda County Health

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.

Behavioral Health Department
Alameda County Health

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

Behavioral Health Department
Alameda County Health

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:

Provider Type	Provider Rates by Minute Individual	Provider Rates by Minute 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

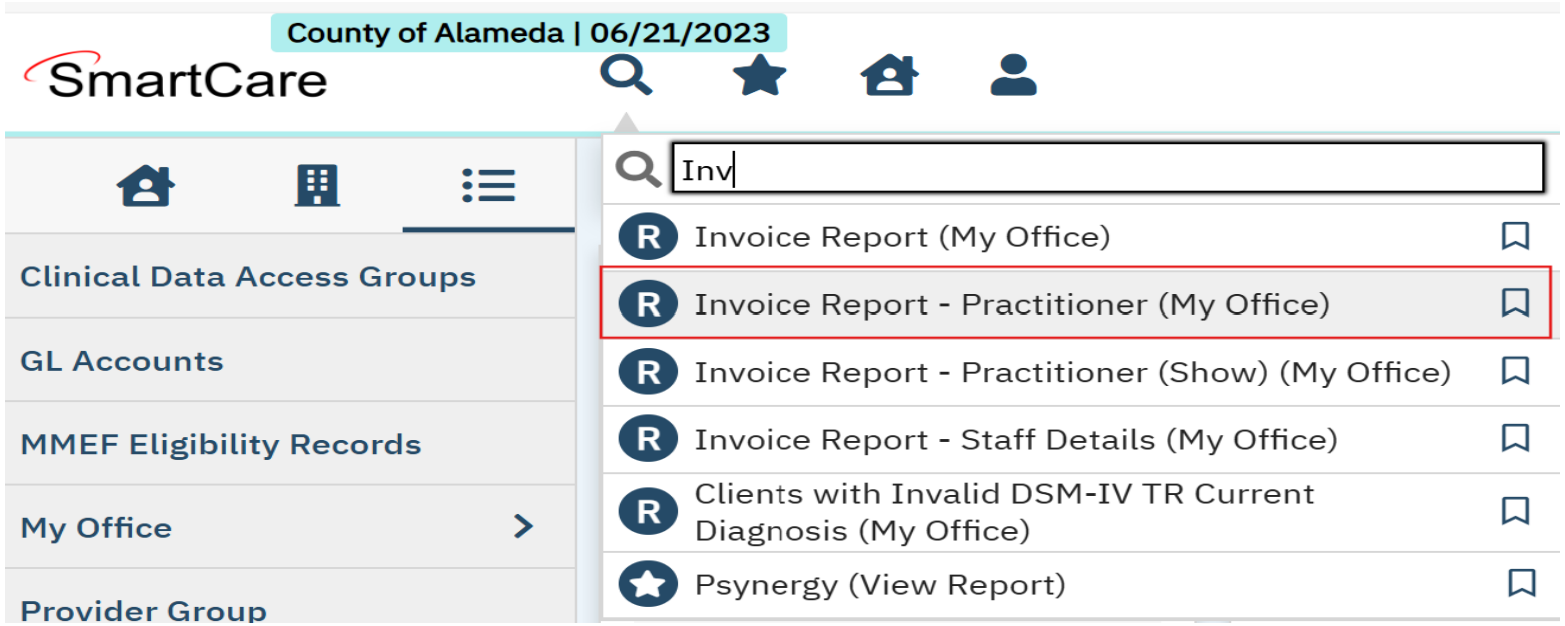
Flat Fee CPT Codes/ Supplemental Services	Provider Flat Rate	Provider Flat Rate
Interactive Complexity (All Types)	$18.89	$18.89

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

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
    - **NOTE:** By typing the first three characters, the drop-down list will begin to populate
- Select the report titled **“Invoice Report - Practitioner (My Office)”**

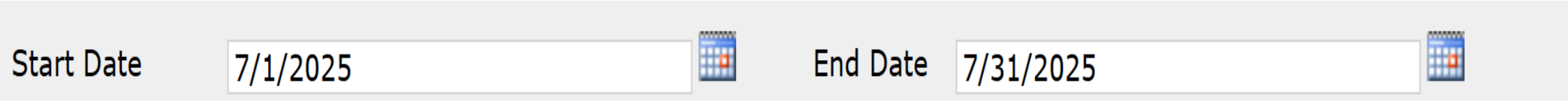


Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

Generating SmartCare Invoice Report

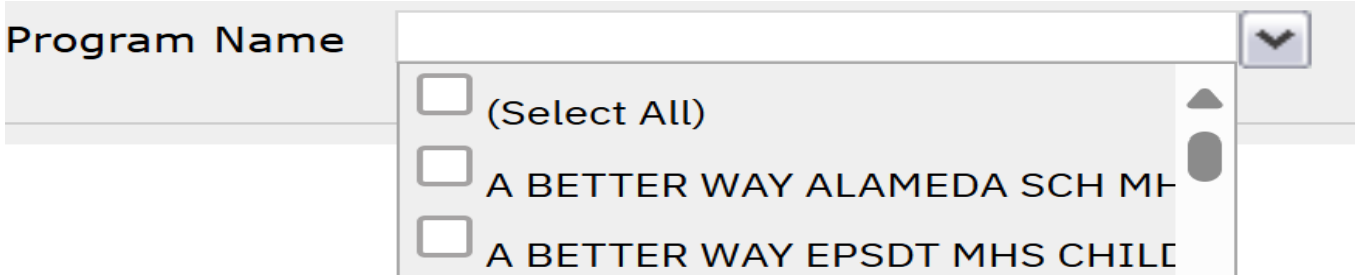
- The report pop-up box will populate in a new window
- Complete the report filters.
  - Add Start and End date.
    - For monthly Provider Claims, the date range should be for the entire service month.
      - Example, for the service period July 2025, the start and end dates will be 07/01/2025-07/31/2025.



Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

- **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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

Generating SmartCare Invoice Report

Behavioral Health Department
Alameda County Health

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 Specialist	33	H2017 Psychosocial Rehab	2.27	0.00	0.28	9	135	3
		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 Group	523	H2017 Group Psychosocial Rehab	5.17	0.00	0.66	21	315	5
		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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

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:

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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
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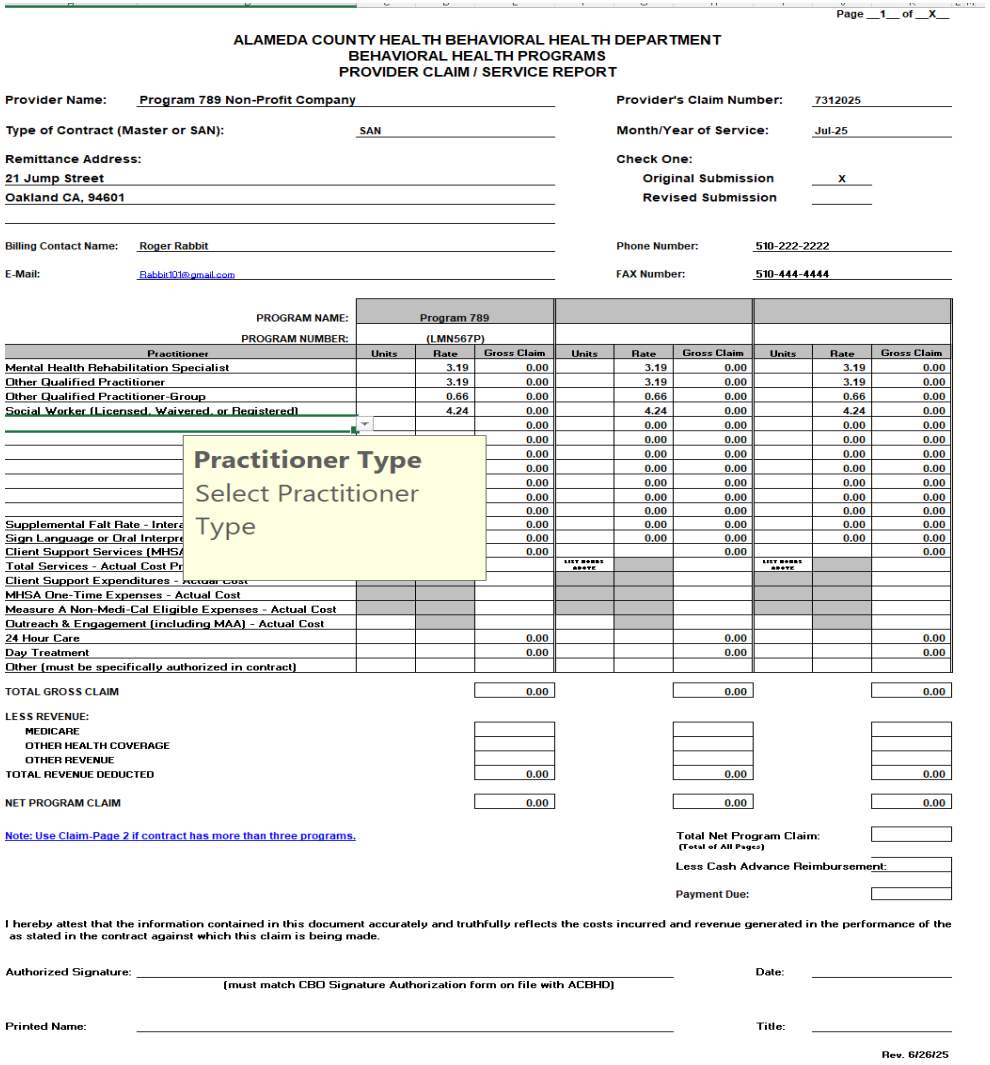
Flat Fee CPT Codes/ Supplemental Services	Provider Flat Rate	Provider Flat Rate
Interactive Complexity (All Types)	$18.89	$18.89



Page __1__ of __X__

ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMENT
BEHAVIORAL HEALTH PROGRAMS
PROVIDER CLAIM / SERVICE REPORT

Provider Name: Program 789 Non-Profit Company
Provider's Claim Number: 7312025
Type of Contract (Master or SAN): SAN
Month/Year of Service: Jul-25
Remittance Address:
21 Jump Street
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission
Billing Contact Name: Roger Rabbit
Phone Number: 510-222-2222
E-Mail: Rabbit101@gmail.com
FAX Number: 510-444-4444

PROGRAM NAME: Program 789
PROGRAM NUMBER: (LMN567P)

Practitioner	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
Mental Health Rehabilitation Specialist		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	0.00
Other Qualified Practitioner-Group		0.66	0.00		0.66	0.00		0.66	0.00
Social Worker (Licensed, Waivered, or Registered)		4.24	0.00		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
			0.00		0.00	0.00		0.00	0.00
Supplemental Fall Rate - Intera			0.00		0.00	0.00		0.00	0.00
Sign Language or Oral Interpre			0.00		0.00	0.00		0.00	0.00
Client Support Services (MHSA			0.00			0.00			0.00
Total Services - Actual Cost Pr				LEAVE BLANK ABOVE			LEAVE BLANK ABOVE		
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			0.00			0.00			0.00
LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
TOTAL REVENUE DEDUCTED			0.00			0.00			0.00
NET PROGRAM CLAIM			0.00			0.00			0.00

Practitioner Type
Select Practitioner Type

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

Total Net Program Claim: (Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due:

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 as stated in the contract against which this claim is being made.

Authorized Signature: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

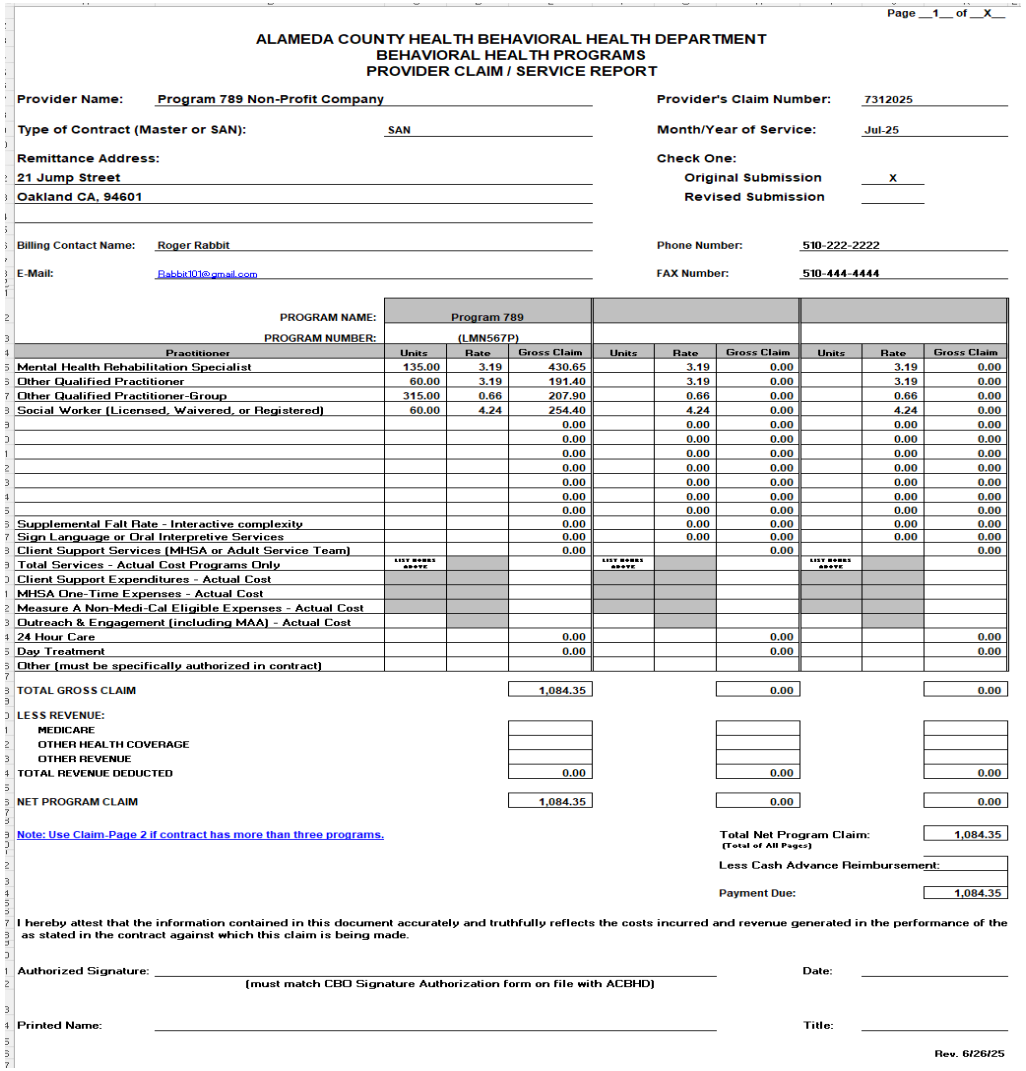
Printed Name: _____ Title: _____

Rev. 6/26/25

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

Provider Claim/Service Report (Invoice) Template and instructions



Page __1__ of __X__

ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMENT
BEHAVIORAL HEALTH PROGRAMS
PROVIDER CLAIM / SERVICE REPORT

Provider Name: Program 789 Non-Profit Company
Provider's Claim Number: 7312025
Type of Contract (Master or SAN): SAN
Month/Year of Service: Jul-25
Remittance Address:
21 Jump Street
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission

Billing Contact Name: Roger Rabbit
Phone Number: 510-222-2222
E-Mail: Rabbit101@gmail.com
FAX Number: 510-444-4444

PROGRAM NAME:	Program 789								
PROGRAM NUMBER:	(LMN567P)								
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		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		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
			0.00		0.00	0.00		0.00	0.00
Supplemental Fall 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)			0.00			0.00			0.00
Total Services - Actual Cost Programs Only	LIST BOXES ABOVE			LIST BOXES ABOVE			LIST BOXES ABOVE		
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:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
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 Program Claim: (Total of All Pages) 1,084.35
Less Cash Advance Reimbursement:
Payment Due: 1,084.35

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 as stated in the contract against which this claim is being made.

Authorized Signature: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

Printed Name: _____ Title: _____

Rev. 6/26/25

Behavioral Health Department
Alameda County Health

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 Specialist	33	H2017 Psychosocial Rehab	2.27	0.00	0.28	9	135	3
		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 Group	523	H2017 Group Psychosocial Rehab	5.17	0.00	0.66	21	315	5
		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**

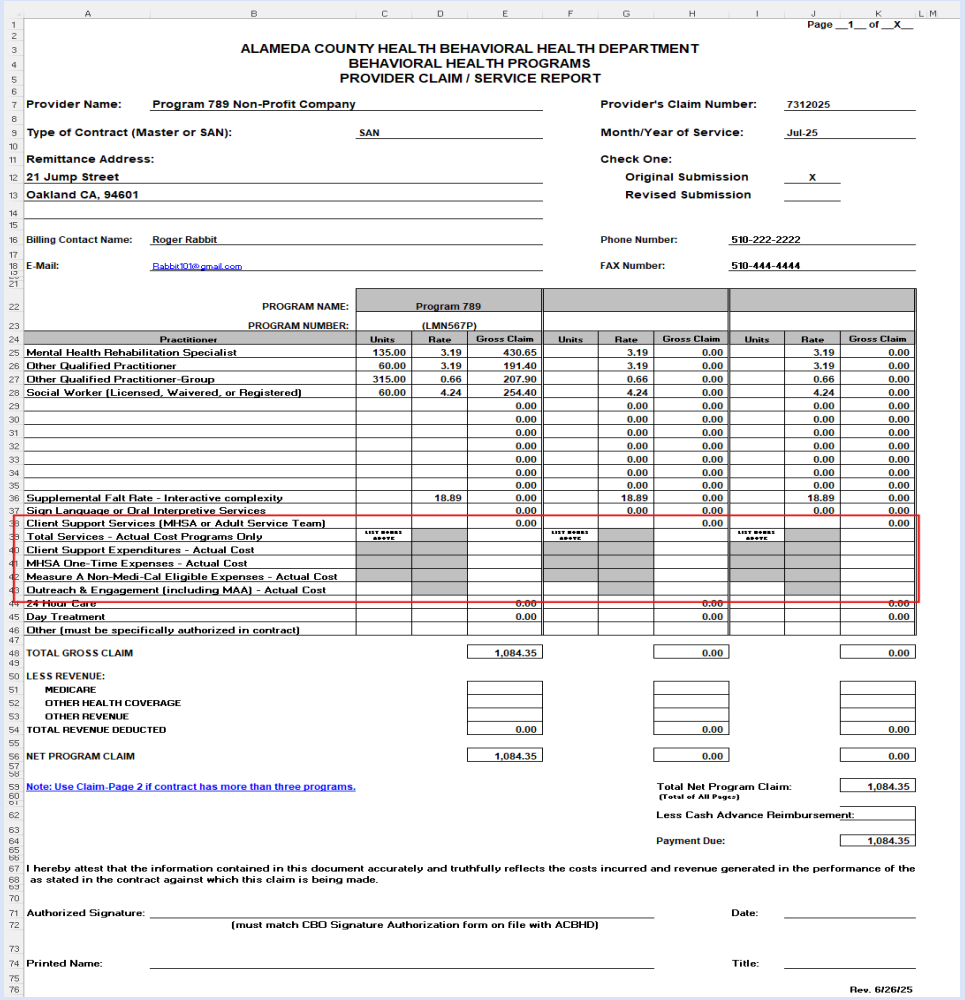
This report is based on **"Completed"** Services only as of run date

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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (By Practitioner)

Provider Claim/Service Report (Invoice) Template and instructions



Page __1__ of __X__

ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMENT
BEHAVIORAL HEALTH PROGRAMS
PROVIDER CLAIM / SERVICE REPORT

Provider Name: Program 789 Non-Profit Company
Provider's Claim Number: 7312025
Type of Contract (Master or SAN): SAN
Month/Year of Service: Jul-25
Remittance Address:
21 Jump Street
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission
Billing Contact Name: Roger Rabbit
Phone Number: 510-222-2222
E-Mail: Rabbit101@gmail.com
FAX Number: 510-444-4444

PROGRAM NAME:	Program 789								
PROGRAM NUMBER:	(LMN567P)								
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		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		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
			0.00		0.00	0.00		0.00	0.00
Supplemental Fall Rate - Interactive complexity		18.89	0.00		18.89	0.00		18.89	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)			0.00			0.00			0.00
Total Services - Actual Cost Programs Only	LIST ROWS ABOVE			LIST ROWS ABOVE			LIST ROWS ABOVE		
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:									
MEDICARE									
OTHER HEALTH COVERAGE									
OTHER REVENUE									
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 Program Claim: 1,084.35
(Total of All Pages)
Less Cash Advance Reimbursement:
Payment Due: 1,084.35

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 as stated in the contract against which this claim is being made.

Authorized Signature: _____ Date: _____
(must match CBO Signature Authorization form on file with ACBHD)

Printed Name: _____ Title: _____

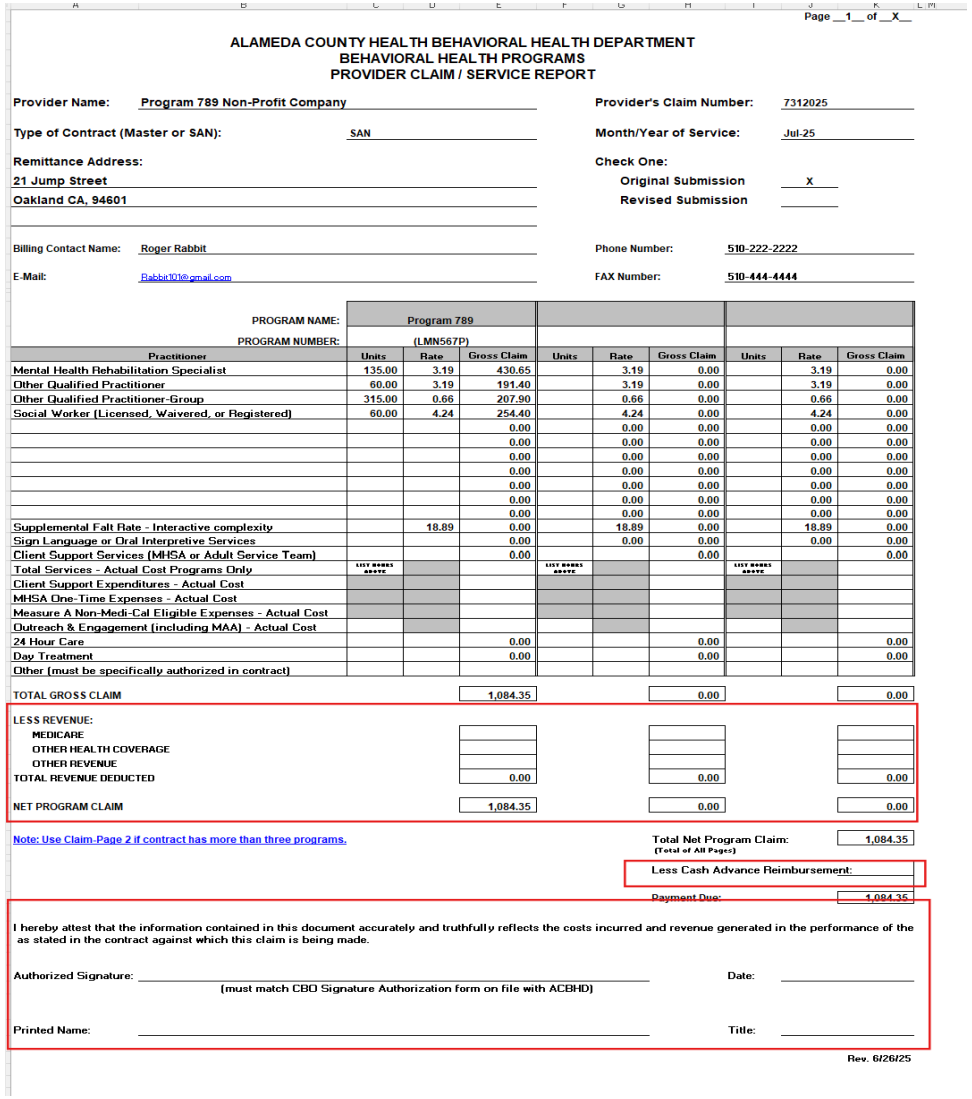
Rev. 6/26/25

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

Behavioral Health Department
Alameda County Health

Invoicing for Treatment Programs (Legacy)

Provider Claim/Service Report (Invoice) Template and instructions



Page __1__ of __X__

ALAMEDA COUNTY HEALTH BEHAVIORAL HEALTH DEPARTMENT
BEHAVIORAL HEALTH PROGRAMS
PROVIDER CLAIM / SERVICE REPORT

Provider Name: Program 789 Non-Profit Company
Provider's Claim Number: 7312025
Type of Contract (Master or SAN): SAN
Month/Year of Service: Jul-25
Remittance Address:
21 Jump Street
Oakland CA, 94601
Check One:
Original Submission X
Revised Submission
Billing Contact Name: Roger Rabbit
Phone Number: 510-222-2222
E-Mail: Rabbit101@gmail.com
FAX Number: 510-444-4444

PROGRAM NAME:	Program 789								
PROGRAM NUMBER:	(LMN567P)								
Practitioner	Units	Rate	Gross Claim	Units	Rate	Gross Claim	Units	Rate	Gross Claim
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			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
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Sign Language or Oral Interpretive Services			0.00		0.00	0.00		0.00	0.00
Client Support Services (MHSA or Adult Service Team)			0.00			0.00			0.00
Total Services - Actual Cost Programs Only	LIST HOURS ABOVE			LIST HOURS ABOVE			LIST HOURS ABOVE		
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									
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Other (must be specifically authorized in contract)									
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LESS REVENUE:									
MEDICARE									
OTHER HEALTH COVERAGE									
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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.

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Printed Name: _____ Title: _____

Rev. 6/26/25

Behavioral Health Department
Alameda County Health

Submit Claims to Accounts Payable (AP) – ACBHD

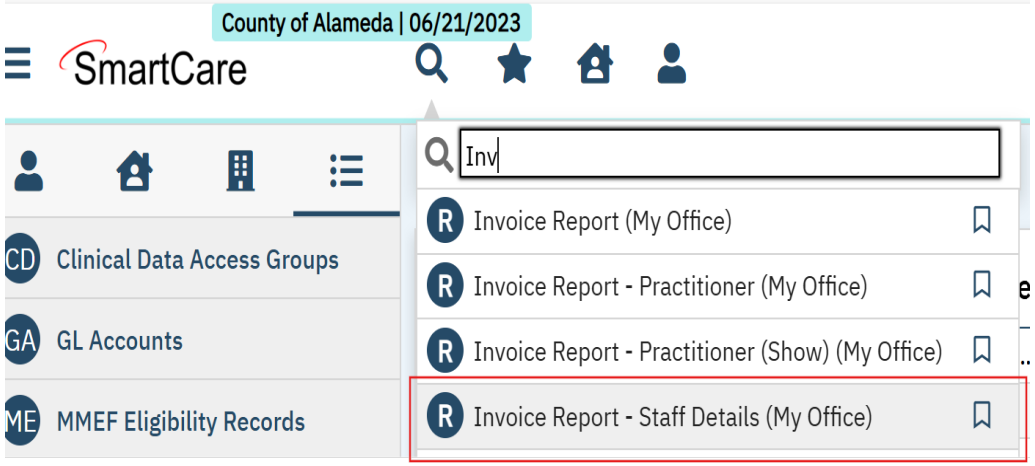
- **Reminder – This is a restructured process between:**
  - Accounts Payable (AP) – ACBHD
  - Disbursement Division – Alameda County Auditor – Controller's office

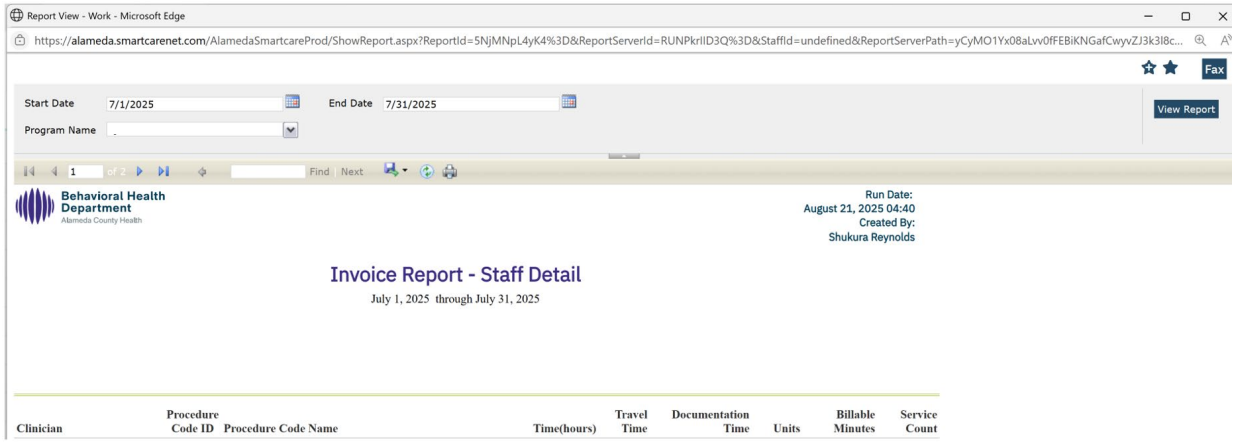
    Submit claims/questions to the AP Unit at:
    CBOPayment@acgov.org
  - Always copy your fiscal contract manager
- **CalWORKS/Grant program invoices due –** 10 Days after end of service month, or by earlier Grant deadline if communicated by ACBHD
- Templates, we will follow up with a communication around 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.

Behavioral Health Department
Alameda County Health

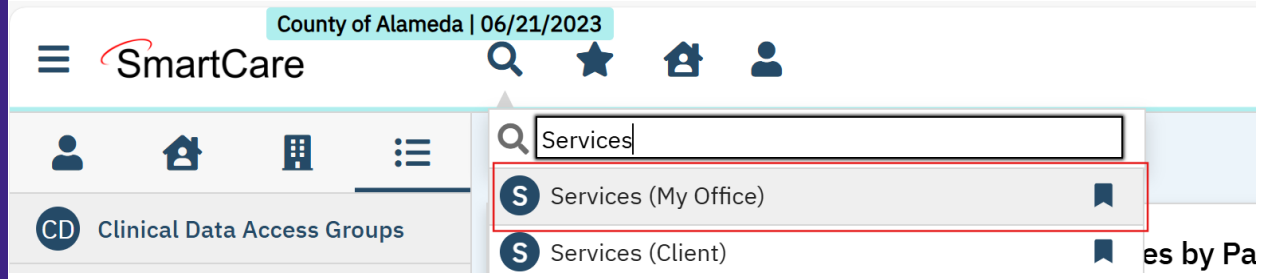
Reconciling SmartCare Service Data

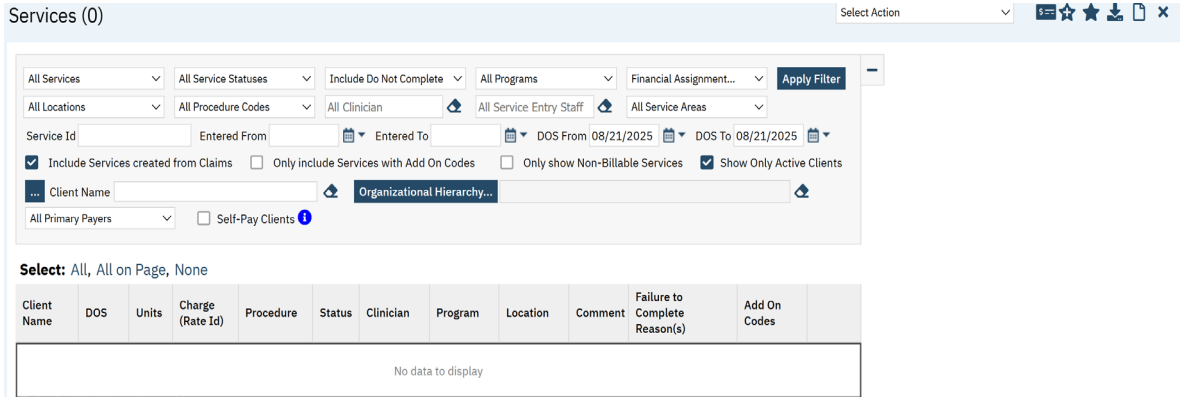
Invoice Report - Staff Details (My Office)





Services (My Office) - List Page





Behavioral Health Department
Alameda County Health

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

Behavioral Health Department
Alameda County Health

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

Behavioral Health Department
Alameda County Health

ACBHD Tools and Resources

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

Behavioral Health Department
Alameda County Health

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: HCSASupport@acgov.org**

Help Desk Phone #: (510) 567-8181

M – F: 8:30 am to 5:00 pm

FAX #: (510) 567-8161

Behavioral Health Department
Alameda County Health

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