MENTAL HEALTH PROGRAMS
PROVIDER CLAIM/SERVICE REPORT INSTRUCTIONS

1) **Enter Provider Name and Claim Number.** Please note that the Claim Number (assigned by the provider) must be a unique number each month and needs to be listed on each page.

2) **Enter Type of Contract (Master), Remittance Address and Month/Year of Service.**

3) **Check "Original Submission" or "Revised Submission."** BHCS does not normally accept "revised submission" except in unique circumstances, so this box should only be used as directed by BHCS. If additional service units are input into InSyst after the original claim submission, adjustments will be made at end-of-year cost report settlement.

4) **Complete the Billing Contact section** including the name of the person who prepared the claim form. This information will be used to contact you if questions arise concerning the claim information you have provided.

5) **Complete the Program Name and RU Number (as shown on the Contract Rate Sheet) for each column.**

   - If the Contract Rate Sheet lists multiple RU Numbers together for one program, then there should just be one column on the claim for all of these RU Numbers.

   - If the Rate Sheet shows just one RU Number or other program type separately, then there also needs to be a separate column on the claim form.

6) **List the number of units for each modality and reporting unit; this will be "hours" for Outpatient or Outreach services and "days" for Day Treatment. For CalWORKs programs, enter the number of reports completed on the lines with the negotiated rate for Engagement Fee, Initial Reporting Fee, and Follow-Up Reporting Fee. Use the "Other" line only if specifically directed to do so by BHCS Staff and as authorized by the contract.** Please do not use links or copy and paste data from any other spreadsheets, as this may create formatting or formula problems.

   - **For Residential and Day Treatment**, use the "**Service Total**" column in the InSyst Report **PSP 131** (Services Summary).

   - **For Outpatient Services and Outreach Programs that have been assigned an RU** number, the service data input by the providers is contained in two InSyst reports: **MHS 854A** (Staff Activity Analysis) **and MHS 854B** (CoStaff Activity Analysis). On Reports MHS 854A and MHS 854B, use the amounts shown in the "**Time/Hours**" column. **Please show the numbers exactly as shown on the InSyst report(s) - do not round.** Contact the HELP DESK (567-8181) if you need assistance in getting or using the reports. Please note that Report MHS 855 shows slightly different data and should not be used for claiming purposes.

   - **For Outreach programs without an assigned RU number**, providers should report **staff time** based on their own records.

7) **Refer to the Contract Rate Sheet to determine the method of reimbursement for each program and enter the contract rates for rate-based programs or actual cost as applicable:**

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

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

- For MHSA "actual cost" programs, enter the total costs on the line labeled "Total Services – Actual Cost Programs Only" for all the MHSA service categories (this applies to all the hours listed on the claim for Mental Health Services, Case Management/Brokerage, Crisis Intervention, Medication Support, Outreach & Engagement (including MAA) and Client Support Services).

- "Client Support Expenditures – Actual Cost" should only be used for MHSA or Adult Service Team programs that have this specifically listed in their budget and would include direct expenditures made for client benefit such as Clothing, Client Travel, Housing, Employment & Education Supports, etc.

- "MHSA One-Time Expenses" is only to be used if this is specifically authorized by the contract (separate budget column) and would include expenditures such as furniture, computers, phones, staff training, recruitment, etc.

- "Measure A Non-Medi-Cal Eligible Expenses" would be for capital and other Non-Medi-Cal eligible expenses that have been specifically authorized and designated as such in the contract; do not include Measure A funding that is used for Medi-Cal Eligible Expenses included in the operational program budget, as this is already factored into the rate for services rendered.

8) Attach the applicable InSyst reports and/or documentation of "actual costs" as applicable.

For all programs with assigned RU numbers (rate-based or actual cost), providers are responsible for entering service data into InSyst by the monthly deadline and attaching the applicable reports to the claim form. Please ensure that the claim numbers match in each service category; do not attach any reports other than MHS 854 (for outpatient or outreach services) or PSP 131 (for day treatment or residential).

For "actual cost" programs, client support expenditures or one-time expenses reimbursement, the provider needs to attach a spreadsheet with rows listing each line-item category from the program budget with corresponding columns for the budget amount, actual costs for the month, and cumulative (year-to-date) actual costs.

9) List all offsetting revenue (directly associated with services provided or revenues included in the budget) by program. The form will then automatically deduct the revenue to determine the Net Program Claim amount in each column. Add these together and enter the Total Net Program Claim amount.

10) If you received a cash advance and are making a repayment, deduct that amount to determine the Payment Due.

11) Sign, date, attach the appropriate documentation and submit the original claim to:

Alameda County Behavioral Health Care
Network Office-Mental Health
Attn: Accounts Payable
1900 Embarcadero Cove, Suite 205
Oakland, CA 94606