**ARTICLE I**

**BUDGET DETAIL AND PAYMENT PROVISIONS**

1. **Invoicing/Claims and Payment**
2. For services satisfactorily rendered, and upon receipt and approval of Contractor’s invoices/claims, California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) agrees to compensate Contractor for completed services in accordance with the rates specified in Exhibit B-1 or Exhibit B-2, Rate Sheet, which is included as part of this Agreement. Except for emergency care, CDCR/CCHCS shall not compensate Contractor for services which did not receive prior authorization in accordance with Exhibit A Scope of Work, and/or Exhibit A-1 Service Specifications and/or exceed the services as defined in California Code of Regulations, Title 15, Section §3350 et seq.
3. Services shall be completed as set forth in Exhibit A, Scope of Work and/or Exhibit A-1, Service Specification and in accordance with prior authorization provisions, and all other terms and conditions of this Agreement.
4. Invoices shall be reimbursed in accordance to Exhibit B-1 or Exhibit B-2, Rate Sheet and with the following terms: no CDCR/CCHCS employee may accept a rate increase request on behalf of CCHCS. Any invoice/claim that is sent to CCHCS with reimbursement rates above that specified by CCHCS in writing within the contract shall be invalid. Payment of an erroneous invoice/claim does not constitute acceptance of the erroneous pricing and CCHCS may seek reimbursement of the overpayment or may withhold such overpayment from future invoices/claims.
5. CDCR/CCHCS will not accept requests for early payment, down payment, or partial payment.
6. **Budget Contingency Clause**
7. It is mutually agreed that if the California State Budget Act for the current fiscal year and/or any subsequent fiscal years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Contractor, or to furnish any other considerations under this Agreement, and Contractor shall not be obligated to perform any provisions of this Agreement.
8. If funding for the purposes of this program is reduced or deleted for any fiscal year by the California State Budget Act, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an Agreement amendment to Contractor to reflect the reduced amount.
9. **Prompt Payment Clause**

Payment will be made in accordance with, and within the time specified in, Government Code (GC) Chapter 4.5, commencing with Section §927. Payment to small/micro businesses shall be made in accordance with, and within the time specified in, GC Chapter 4.5, Section §927 et seq.

1. **Subcontractors**

For all Agreements, with the exception of Interagency Agreements and other governmental entities/auxiliaries that are exempt from bidding, nothing contained in this Agreement, or otherwise, shall create any contractual relationship between the State and any subcontractors, and no subcontract shall relieve the Contractor of Contractor’s responsibilities and obligations hereunder. Contractor agrees to be as fully responsible to the State for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them, as it is for the acts and omissions of persons directly employed by the Contractor. The Contractor’s obligation to pay its subcontractors is an independent obligation from the State’s obligation to make payments to the Contractor. As a result, the State shall have no obligation to pay or to enforce the payment of any monies to any subcontractor.

**ARTICLE II**

**SPECIAL BUDGET DETAIL AND PAYMENT PROVISIONS**

1. **Confidentiality of Exempt or Emergency Agreement Rates**

CDCR/CCHCS is exempt from publicly disclosing the rates of payment contained in CDCR/CCHCS health care Agreements for four (4) years after the date of execution of an Agreement or an Agreement amendment per GC Section §6254.14. CDCR/CCHCS is also exempt from publicly disclosing the terms and conditions contained in CDCR/CCHCS health care Agreements for one (1) year after the date of execution of an Agreement or Agreement amendment per GC Section §6254.14. Except for required disclosures set forth in GC Section §6254.14, CDCR/CCHCS and Contractor agree to protect the confidentiality of the rates contained in this Agreement or Agreement amendment for four (4) years after the date of execution in accordance with the appropriate GC.

1. **Orientation Hours**

At the discretion of each institution/facility, Contractor shall ensure that on-site health care service providers complete orientation as specified in Exhibit A, Scope of Work.

1. **On-Site Institution Orientation**

For on-site institution classroom orientation, Contractor agrees that prior to reporting to work at the institution/facility, all on-site health care service providers shall attend classroom orientation. Classroom orientation will include any required training to become familiar with the operations of the institution/facility and its medical facilities, Title 15 of the California Code of Regulations, Director’s Rules and Regulations, and any bylaws that may apply to the institution/facility.

Contractor shall be paid for the time spent in classroom orientation once the on-site health care service provider has worked a minimum of eighty (80) hours in excess of the orientation hours. Contractor shall not be compensated for the time spent in classroom orientation if the provider does not work a minimum of eighty (80) hours in excess of the classroom orientation hours.

Compensation for classroom orientation will be paid at one-half (1/2) of the hourly rate of the on-site health care service providers for a maximum of forty (40) hours of orientation. Any orientation required by the institution/facility exceeding forty (40) hours will be reimbursed at the rate identified in Contractor’s Rate Sheet (Exhibit B-2). Orientation shall not be invoiced until after eighty (80) hours have been worked over and above the orientation hours.

1. **Self-Certification Orientation Process (On-Site Health Care Service Providers Orientation)**

This process may be utilized in place of attending on-site institution orientation based on institution approval. The Health Program Specialist in the Medical Contracts Section will provide notification when this process is allowed for a specific institution.

1. Link: <http://www.cdcr.ca.gov/Divisions_Boards/Plata/Orientation_Information.html>
2. Contractor shall be responsible for ensuring that on-site health care service providers complete the orientation and sign the CCHCS Orientation Acknowledgement Letter.
3. Contractor shall maintain the signed copy of the CCHCS Orientation Acknowledgement Letter and provide to CDCR/CCHCS upon request.
4. **Submission of Invoices/Claims**
5. In order to ensure prompt and accurate payment, all invoices/claims shall be submitted according to the applicable directions listed below for each service type. **It is the responsibility of the Contractor to ensure that invoices/claims are sent to the correct address as set forth below according to service type**. Invoices/claims that are not sent to the appropriate address will be deemed not to have been submitted, will not be processed for payment, and will not be subject to late payment penalties. (GC Chapter 4.5 Section §927.2, subdivision (j) and §927.4)
6. All invoices/claims must be completed thoroughly, with all applicable fields completed. Invoices/claims that are submitted to the appropriate location, but have been altered, are inaccurate, or do not provide all necessary information, will not be accepted and will be returned to Contractor for correction.
7. Any changes to this provision relating to the invoice/claim submittal process, including but not limited to an address, form, or process change, shall be an administrative change managed through the appropriate designated CDCR/CCHCS office **and shall not require an Agreement amendment*.***
8. All invoices/claims shall include the Agreement number and shall not be submitted more frequently than monthly in arrears, with the exception of the Procedure Based Billing provision of this Exhibit.
9. Invoices/claims submitted shall include the following information and must be legible in order to be considered complete and acceptable for processing or the invoice/claim will be returned and disputed back to Contractor. Disputed/returned invoices/claims shall not be subject to late payment penalties, as set forth in GC Chapter 4.5, Section §927.4.

**Refer to type of service in STD 213 Standard Agreement, Section 4 to determine which of the following billing instructions will apply.**

1. **Contractors of Temporary/Relief Registry Services**
2. Contractors of temporary/relief registry services shall submit both an invoice/claim and timesheet for reimbursement.
3. Invoices/claims submitted for payment shall include the following information and must be legible in order to be considered complete and acceptable for processing, or the invoice/claim will be returned to Contractor for correction.
4. Contractor name on Agreement
5. Agreement number
6. Contractor address, phone number, and e-mail
7. Contractor Federal Employer Identification Number (FEIN)/Federal Tax ID
8. Invoice/claim number
9. Date of invoice/claim
10. Date(s) of service
11. Grand total dollar amount
12. First and Last name of Contractor or Provider performing services
13. Contractor or Provider’s National Provider Identification (NPI) Number
14. Contractor’s or Provider’s Classification
15. Institution/facility where services were performed
16. Actual location and area where services were performed (Medical, Mental Health, Dental)
17. Hourly rate
18. Types of services
19. Summary of total hours worked in each service area (Medical, Mental Health, Dental)
20. Summary of total dollar amount for each service area (Medical, Mental Health, and/or Dental)
21. Regular hours worked
22. Orientation, on-call, call-back, or unanticipated hours worked (if applicable)
23. Grand total of hours worked
24. Number of patients/youth seen (if applicable)
25. Names(s) of patient(s)/youth (if applicable)
26. Patient’s CDCR number and/or Person Identification (PID) number/DJJ Youth Authority (YA) number (if applicable)
27. Timesheets submitted for temporary/relief registry services shall include the following information and must be legible in order to be considered acceptable for processing. Any timesheets submitted that are illegible or incomplete shall be returned to Contractor for correction.
28. Date(s) of service
29. First and Last name of Contractor or Provider performing services
30. Last four (4) digits of the Provider’s Social Security Number
31. Contractor’s or Provider’s classification
32. Institution/facility where services were performed
33. Total hours provider worked listed separately by regular, unanticipated, orientation, on-call, or call-back hours
34. Contractor shall invoice/claim the exact time that the provider provided services during the scheduled shift. Contractor shall not approximate or round hours reported on timesheets. Any provider who arrives early, prior to their scheduled starting time, or who remains beyond the scheduled ending time, will not be paid for such periods
35. Actual location and service area where medical services performed (Medical, Mental Health, Dental)
36. Number of patients/youth seen (if applicable)
37. Contractor or Provider printed name, signature, and date
38. CDCR authorized designee’s printed name, classification, approval signature, and date signed for all hours
39. Invoices/claims and timesheets shall be submitted to the following address:

California Correctional Health Care Services

Healthcare Invoicing Section, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Contractors of Non-Registry or On-site Physician Services**
2. Contractors of non-registry or on-site physician services shall submit an invoice/claim for reimbursement.
3. Invoices/claims submitted for payment shall include the following information and must be legible in order to be considered complete and acceptable for processing, or the invoice/claim will be returned to Contractor for correction.
4. Contractor name on Agreement
5. Agreement number
6. Contractor address, phone number, and e-mail
7. Contractor Federal Employer Identification Number (FEIN)/Federal Tax ID
8. Invoice/claim number
9. Date of invoice/claim
10. Date(s) of service
11. Grand total dollar amount
12. First and Last name of Contractor or Provider performing services
13. Contractor or Provider’s National Provider Identification (NPI) Number
14. Contractor’s or Provider’s Classification
15. Institution/facility where services were performed
16. Hourly rate
17. Type(s) of services
18. Time in, time out
19. Summary of total hours worked in each service area (Medical, Mental Health, Dental)
20. Summary of total dollar amount for each service area (Medical, Mental Health, and/or Dental)
21. Orientation, on-call, call-back, or unanticipated hours worked (if applicable)
22. Grand total hours worked
23. Number of patients/youth seen (if applicable)
24. Name(s) of patient(s)/youth (if applicable)
25. Patient’s CDCR number and/or Person Identification (PID) number/DJJ Youth Authority (YA) number (if applicable)
26. Copy of the ducat/appointment list provided by the institution/facility. Ducat must include patient’s CDCR number and/or Person Identification (PID) number/DJJ Youth Authority (YA) number (if applicable)
27. Any other medical information or documentation from external sources reasonably required to verify and substantiate the provision of services and the charges for such services
28. Invoices/claims submitted for non-registry or on-site physician services reimbursed at an **hourly** **rate** shall be mailed to the following address:

California Correctional Health Care Services

Healthcare Invoicing Section, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Physician Directorship Services**
2. Contractors of on-site physician directorship services shall submit an invoice/claim for reimbursement.
3. Invoices/claims submitted for payment shall include the following information and must be legible in order to be considered complete and acceptable for processing, or the invoice/claim will be returned to Contractor for correction.
4. Contractor name on Agreement
5. Agreement number
6. Contractor address, phone number, and e-mail
7. Contractor Federal Employer Identification Number (FEIN)/Federal Tax ID
8. Invoice/claim number
9. Date of invoice/claim
10. Date(s) of service
11. Grand total dollar amount
12. First and Last name of Contractor or Provider performing services
13. Contractor or Provider’s National Provider Identification (NPI) Number
14. Contractor’s or Provider’s Classification
15. Institution/facility where services were performed
16. Type(s) of services
17. Grand total hours worked
18. Documented phone consults, if any
19. Any other medical information or documentation from external sources reasonably required to verify and substantiate the provision of services and the charges for such services
20. Invoices/claims submitted for on-site physician directorship services shall be mailed to the following address for processing:

California Correctional Health Care Services

Healthcare Invoicing Section, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Submission of Claims to the Third Party Administrator (Procedure Based Billing)**
2. Information concerning invoices/claims adjudicated for CCHCS by CorrectCare Integrated Health (CCIH) may be accessed through the CCIH Web Portal. Instructions for registration and use of the web portal along with electronic billing information can be obtained by calling the CCHCS Healthcare Invoicing Section (HIS) Help Desk at (916) 691-0699 or at:

<http://www.correctcare.com/portal/>

1. Pursuant to the California Prompt Payment Act, GC Chapter 4.5, Section §927 et seq, undisputed invoices/claims shall be paid within forty-five (45) days of the date of receipt. Invoice/claim billing cycles shall be restricted to sixty (60) days from original invoice/claim submission date or after the Contractor has verified the invoice(s)/claim(s) are not in the CCIH Web Portal waiting processing. If you do not have access to the CCIH Web Portal, contact the HIS Help Desk at (916) 691-0699 to verify receipt of invoices/claims.
2. CDCR/CCHCS shall render payment in accordance with and within the time specified in GC Chapter 4.5, Section §927 et seq. CDCR/CCHCS reserves the right to deny a Contractor’s invoice/claim if Contractor fails to submit it in the appropriate format or within the appropriate time frame specified in this Section. The CDCR/CCHCS will provide an explanation along with the invoice/claim denial and the basis for invoice/claim rejection. The Contractor will have the right to appeal or otherwise resubmit the invoice/claim with the reasonably required documentation.
3. Invoices/claims submitted for payment must be typewritten, legible and accurate and submitted within one hundred twenty (120) calendar days after the provision of services. Invoices/claims submitted after one hundred twenty (120) calendar days may not receive payment for these invoices/claims. Invoices/claims older than one hundred twenty (120) calendar days shall be submitted in accordance with Exhibit D, Special Terms and Conditions & Additional Provisions, Section 1, Dispute Resolution, (b)(3) Formal Claims Appeal.

**Refer to type of service in STD 213 Standard Agreement, Section 4 to determine which of the following billing instructions will apply.**

1. **Professional Services**
2. Invoices/claims submitted for payment of on/off-site professional services shall be on a Centers for Medicare and Medicaid (CMS) CMS-1500 form or its successor(s) (if applicable) and shall itemize each service provided.
3. Invoices/claims submitted for payment of on/off-site professional services shall include all applicable information listed below:
4. Patient’s CDCR number and/or DJJ Youth Authority (YA) number (if applicable)
5. Name of patient/youth
6. Patient/youth date of birth
7. Gender of patient/youth
8. Patient/youth housing institution/facility acronym, city, state, and zip code
9. All required diagnosis codes
10. Prior authorization number (future requirement)
11. Date(s) of service
12. Place of service
13. All required Current Procedure Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes
14. Service units
15. Billed charges for services rendered (including total billed charges)
16. Contractor or Provider’s National Provider Identification (NPI) Number
17. Contractor Federal Employer Identification Number (FEIN)/Federal Tax ID
18. Patient/youth account number (as assigned by the billing entity)
19. First and Last name of Contractor or Provider performing services (In the event that the Contractor or Provider is a medical group, list the group name. The NPI number should reflect this listing.)
20. Service facility location information
21. Billing provider information
22. Any other medical information or documentation from external sources reasonably required to verify and substantiate the provision of services and the charges for such services
23. Invoices/claims submitted for on/off-site professional services shall be mailed to the Third Party Administrator at the following address:

CorrectCare Integrated Health

P.O. Box 349026

Sacramento, CA 95834-9026

1. **Hospital/Surgery Centers**
2. Invoices/claims submitted for payment for hospital/surgery center services shall be on a CMS-1450 (UB-04) or its successor(s) (if applicable) and shall itemize each service provided.
3. Invoices/claims submitted for payment of hospital/surgery center services shall include all applicable information listed below:
4. Contractor name and address listed on Agreement

For multiple Hospital/Surgery Centers, the Program name must be listed below the Contractor’s name.

1. Service facility name and address

For multiple Hospital/Surgery Centers, the Program name must be listed below the Service Facility name.

1. Contractor Federal Employer Identification Number (FEIN)/Federal Tax ID
2. Date of invoice/claim
3. Name of patient/youth
4. Patient/youth housing institution/facility acronym, city, state, and zip code
5. Patient/youth date of birth
6. Gender of patient/youth
7. Date(s) of service
8. Patient CDCR number and/or DJJ Youth Authority (YA) number
9. All required diagnosis codes
10. Prior authorization number (future requirement)
11. Appropriate bill type
12. Revenue code(s)
13. All required Current Procedure Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes
14. Service units
15. Billed charges for services rendered (including total billed charges)
16. Contractor or Provider’s National Provider Identification (NPI) number
17. Patient/youth account number (as assigned by the billing entity)
18. First and Last name of Contractor or Provider performing services (In the event that the Contractor or Provider is a medical group, list the group name. The NPI number should reflect this listing.)
19. Diagnosis Related Group (DRG) Code for all in-patient admissions (if applicable)
20. Service facility location information
21. Billing provider information
22. Any other medical information or documentation from external sources reasonably required to verify and substantiate the provision of services and the charges for such services
23. Invoices/claims submitted for hospital/surgery center services shall be mailed to the Third Party Administrator at the following address:

CorrectCare Integrated Health

P.O. Box 349026

Sacramento, CA 95834-9026

1. **Dental Services**
2. Invoices/claims submitted for payment of on/off-site dental services shall be on a 2012 American Dental Association (ADA) form or its successor(s) (if applicable) and shall itemize each service provided.
3. Invoices/claims submitted for payment of on/off-site dental services shall include all applicable information listed below:
4. Name of patient/youth
5. Patient/youth date of birth
6. Patient’s CDCR number and/or DJJ Youth Authority (YA) number
7. Gender of patient/youth
8. Patient/youth housing institution/facility acronym, city, state, and zip code
9. All required diagnosis codes
10. Prior authorization number (future requirement)
11. Date of invoice/claim
12. Date(s) of service
13. Place of service
14. All required Current Dental Terminology (CDT)/Procedure Codes (D-codes)
15. Tooth number(s) (if applicable)
16. Service units
17. Billed charges for services rendered (including total billed charges)
18. Contractor or Provider’s National Provider Identification (NPI) Number
19. Contractor Federal Employer Identification Number (FEIN)/Federal Tax ID
20. Patient/youth account number (as assigned by the billing entity)
21. First and Last name of Contractor or Provider performing services (In the event that the Contractor or Provider is a medical group, list the group name. The NPI number should reflect this listing.)
22. Service facility location information
23. Billing provider information
24. Any other medical information or documentation from external sources reasonably required to verify and substantiate the provision of services and the charges for such services
25. Invoices/claims submitted for on/off-site **Procedure Based** dental services shall be mailed to the Third Party Administrator at the following address:

CorrectCare Integrated Health

P.O. Box 349026

Sacramento, CA 95834-9026

1. **Travel Reimbursement**

 **This Provision is for Emergency Purposes only and shall only be utilized in addressing Emergency Access to Care needs.**

1. If this provision is applicable with regards to this Agreement language stating such shall be referenced in either Exhibit B-1 or Exhibit B-2, Rate Sheet, which is included as part of this Agreement.
2. In order to be reimbursed for travel, Contractor and/or Provider must forward an original signed State Travel Expense Claim (TEC), Standard Form (STD) 262, along with the following items:
3. An itemized invoice/claim provided by the Contractor and/or Provider indicating where services were performed
4. A map showing mileage
5. Receipts and/or any other supporting documentation
6. Items shall be sent to the institution/facility contract liaison or designee for review and verification. Contractor’s and/or Provider’s TEC must be approved and signed by the CCHCS Medical Contracts Section Manager, or a CDCR Institution’s Chief Executive Officer/Chief Medical Executive or designee or DJJ Facility Chief Medical Officer or designee.
7. The institution/facility contract liaison or designee shall submit the approved TEC, with all associated documentation, to the following address:

Accounting Services Branch - Sacramento

Attention: Accounts Payable A

P.O. Box 187015

Sacramento, CA 95818-7015

1. **Reimbursement for Goods**
2. Agreements that contain a goods component such as, but not limited to: hearing aids, eye glasses, prosthetics, and/or orthotics, shall submit health care service invoices/claims separately (e.g. a Contractor or Provider who conducts a hearing test and supplies hearing aids shall submit one invoice/claim for the hearing test and a separate invoice/claim for the hearing aid). Invoices/claims shall also include the Agreement Number and the Purchase Order Number.
3. Health care goods, equipment, and suppliesmust be reviewed and approved prior to a Contractor’s and/or Provider’s submittal of an invoice/claim for payment by the ordering Institution/Facility. Approved health care goods, equipment, and supply invoices/claims shall be mailed to the following address:

Accounting Services Branch - Sacramento

Attention: Accounts Payable A

P.O. Box 187015

Sacramento, CA 95818-7015

1. Invoices/claims submitted for payment of related health care services shall be submitted, separately from the goods component, to the service-specific mailing address within this Agreement.

Procedure-Based Billing

CorrectCare Integrated Health

P.O. Box 349026

Sacramento, CA 95834-9026

On-Site Clinic (Hourly/Registry)

California Correctional Health Care Services

Healthcare Invoicing Section, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Cancellation Fee (refer to Exhibit A – Scope of Work, if applicable)**
2. Contractor shall submit an invoice/claim for Cancellation Fee reimbursement.
3. Invoices/claims submitted for Cancellation Fee reimbursement must be typewritten, legible and accurate in order to be considered complete and acceptable for processing or documents will be returned to Contractor for correction.
4. Invoices/claims submitted for the Cancellation Fee shall include all applicable information listed and submitted to the address listed below:
5. First and Last name of Contractor or Provider performing services
6. Types of services or Contractor or Provider’s classification
7. Institution/facility where services were scheduled to be performed
8. Date(s) of scheduled on-site clinic/shift
9. Scheduled on-site clinic/shift hours
10. Reason(s) for the cancellation
11. Documentation to support the scheduled clinic/shift and cancellation

California Correctional Health Care Services

Healthcare Invoicing Section, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Rejection of Contractor’s Invoice/Claim**

CDCR/CCHCS reserves the right to reject a Contractor’s invoice/claim if Contractor fails to submit the invoice/claim in the appropriate format or within the appropriate timeframe specified within this Agreement. Disputed invoices/claims will be returned to Contractor without payment and will include an explanation of the invoice/claim dispute. Contractor will have the right to appeal or otherwise resubmit the invoice/claim with the pertinent documentation to the addresses below. Disputed/returned invoices/claims shall not be subject to late payment penalties, as set forth in GC Chapter 4.5, Section §927.4.

Procedure-Based Billing

CorrectCare Integrated Health

P.O. Box 349026

Sacramento, CA 95834-9026

On-Site Clinic (Hourly/Registry)

California Correctional Health Care Services

Healthcare Invoicing Section, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Invoice/Claim Billing Appeals**

For disagreements regarding claim payments, or claim denials by CCHCS for a claim billed under the Agreement, Contractor may submit a formal Appeal letter with a copy of the claim originally submitted, a cover page detailing the reason(s) why Contractor believes the claim was underpaid, overpaid, or denied in error, any documentation provided by CCHCS explaining the payment adjustment and any other documentation in support of the Appeal to the following address:

California Correctional Health Care Services

Attn: Healthcare Invoicing Section Appeals Team, Building D-2

P.O. Box 588500

Elk Grove, CA 95758

1. **Invoice/Claim Payment Inquiry**

Should a Contractor have questions or concerns regarding the processing and/or payment of health care invoices/claims, the parties shall make a first attempt in good faith to resolve the dispute or question by informal discussion(s). The parties agree that the CCHCS HIS should be used as a resource in solving potential patient/youth health care invoice/claim disputes. Contractor shall refer to Exhibit D Special Terms and Conditions & Additional Provisions, of this Agreement for detailed dispute information.

1. **Healthcare Invoicing Section Help Desk**

Contractor shall contact the Healthcare Invoicing Section Help Desk at (916) 691-0699 with any questions or clarifications regarding the health care invoice/claim submittal or dispute process. If resolution to the patient/youth invoice/claim cannot be resolved via the verbal inquiry process, Contractor shall refer to the formal health care invoice/claims appeal process outlined in Exhibit D Special Terms and Conditions & Additional Provisions of this Agreement.