State of California - Health and Human Services Agency

Department of Alcohol and Drug Programs

## MULTIPLE BILLING OVERRIDE CERTIFICATION

COUNTY: _____

[ ] DUPLICATE ERROR CORRECTION DATE:_____ [ ] ADP 1584 FORMS

CLAIM FOR MONTH/YEAR:_____ FISCAL YEAR:_____ PROGRAM CODE: _____

Please complete this certification form (for override code "Y") for multiple services provided to a client for the same day.

| PROV CODE | CLAIM ID AND LINE NUMBER | BATCH NUMBER | CLIENT NAME (last, first Initial) | TYPE OF SERVICE PROVIDED | SERVICE DATE | UNITS BILLED | REASON |
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**OVERRIDE REASON:**

1. The client could not receive all necessary services at one time. The client record clearly documents the date and time of day each visit was made and that the return visit was not a hardship on the client.
2. Crisis visit. Services are documented in client record.
3. Collateral services. Services are documented in client record.
4. This service has been erroneously billed and has been reported to the Department of Alcohol and Drug Programs, by the provider, on Adjustment form ADP 5035B. (A copy of the Adjustment form must be attached)
5. This is a duplicate claim due to a key entry error by the state (a copy of the original claim and the error correction report must be attached).

*I hereby certify that I am authorized to represent the county. I recognize that the services specified above have been identified by the automated Short-Doyle/Medi-Cal claim processing system as those which are potentially duplicative or otherwise inappropriate. I further certify that I have reviewed the client record specified above and have determined that the services billed were necessary and appropriate.*

Signature: _____ Date: _____

Title: _____

**RETAIN THE ORIGINAL CERTIFICATION ALONG WITH THE COPY OF THE MONTHLY CLAIM OR THE ERROR CORRECTION REPORT NOTED ABOVE.**
**THIS DOCUMENT MUST BE PRODUCED ON DEMAND FOR AUDIT OR SITE VISIT BY ADP.**