Forms Reorder Request: Inpatient and Outpatient Services

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This section explains how to complete the *Provider Forms Reorder Request*. Providers who need a Provider Forms Reorder Request for either hard copy or electronic billing should contact the Telephone Service Center (TSC) at 1-800-541-5555.

CALIFORNIA MMIS
FISCAL INTERMEDIARY

PROVIDER FORMS REORDER REQUEST
for INPATIENT and OUTPATIENT

FORM NUMBER	TITLE (1)	INDICATE QUANTITY DESIRED (X)				OTHER (Indicate Amount)	ENVELOPES (Indicate Amount) (500 per box) (2)
		100	900	1200	2500		
	(91216-E) Envelopes for INPATIENT						
	(91216-E) Envelopes for OUTPATIENT						
18-1	REQUEST FOR EXTENSION OF STAY IN HOSPITAL (TAR) 4-Part (1200 per box)						
18-1C	REQUEST FOR EXTENSION OF STAY IN HOSPITAL (TAR) 4-Part (Continuous Pin-Fed) (750 per box)						
18-2	REQUEST FOR EXTENSION OF STAY IN HOSPITAL (TAR) 1-Part (FAX) (2500 per box)						
50-1	TREATMENT AUTHORIZATION REQUEST (TAR) 4-Part (900 per box)						
50-1C	TREATMENT AUTHORIZATION REQUEST (TAR) 4-Part (Continuous Pin-Fed) (700 per box)						
50-2	TREATMENT AUTHORIZATION REQUEST (TAR) 1-Part (FAX) (2500 per box)						
50-2C	TREATMENT AUTHORIZATION REQUEST (TAR) 1-Part (Continuous Pin-Fed/FAX) (2700 per box)						
60-1	CLAIMS INQUIRY (CIF) 2-Part (1200 per box)					2000	100
60-1C	CLAIMS INQUIRY (CIF) 2-Part (Continuous Pin-Fed) (1250 per box)						
90-1	APPEAL 2-Part (1200 per box)	X					50

IF YOU HAVE QUESTIONS REGARDING CHANGE OF ADDRESS, PLEASE CALL 1-800-541-5555.

ORDER ONLY A 2- to 3-MONTH SUPPLY, ALLOWING 2-3 WEEKS FOR DELIVERY.

INPATIENT PROVIDER NUMBER (4)
OUTPATIENT PROVIDER NUMBER

(3)
SHIP-TO ADDRESS: (MUST BE COMPLETED.)
(CANNOT SHIP TO P.O. BOX.)

ATTENTION:

Note: Provider number or billing service submitter number must be entered or orders cannot be processed.

CONTACT PERSON:

PHONE NUMBER:

#204 PROPubs 12/18

***Figure 1**. Sample California MMIS Fiscal Intermediary Provider Forms Reorder Request for Inpatient and Outpatient.*

Explanation of Form Items

Item	Description
1.	INDICATE QUANTITY DESIRED (X): Mark one of the quantity boxes or indicate “other” amount desired.
2.	ENVELOPES: Indicate number of envelopes requested. (500 envelopes per box)
3.	SHIP-TO ADDRESS: Enter the name and address where the forms are to be shipped. Include an “Attention” line if applicable. Do not use a P.O. Box.
4.	PROVIDER NUMBER: The provider number or billing service submitter number must be in this box or the Provider Forms Reorder Request form will be returned.

Request for Mental Health Stay in Hospital (18-3)

To order *Request for Mental Health Stay in Hospital* (18-3) forms, enter “18-3 TAR Forms” next to the quantity ordered on the “18-1” line of the FI *Provider Forms Reorder Request*. Complete the rest of the request as previously described.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.