

# eBilling, eAttendance & EFT Payment Processing Agreement

## Overview

A Vendor Administrator must be established in every service provider organization. The Vendor Administrator is responsible for determining which employees within the organization will have access and submission rights in the eBilling/eAttendance application, deactivating access for employees who terminate employment, and notifying the regional center within 24 hours of any changes to the Vendor Administrator assignment.

The Vendor Administrator or designated representative must complete this enrollment and agreement packet in its entirety, sign it, and return it to **pos@altaregional.org** or by fax at **(916) 978-6288**, Attn: Accounting. Email or fax is preferred over U.S. mail service.

## Helpful Resource Links

[eBilling Training Documents & Payment Schedule](#)

[POS Accounting Directory — Who to Contact](#)

[DDS eBilling login](#)

[Electronic Authorizations Enrollment](#)

Tip: the links above are live and can be clicked directly from this PDF.

# Electronic Billing Agreement Form

## Enrollment Process

Complete a separate agreement form for each Service Provider Number.

Service Provider Name

Service Provider Vendor Number

Name of Governing Body or Management Org  
(if applicable)

Mailing Address

Service Address

Email Address

Contact Person Name

Phone Number

For Regional Center Use Only

Service Code

Sub-Code

Checkbox Calendar	Type	Description
Y	Y	Monthly Residential Services
Y	N	Monthly Non-Residential Services
N	N	Units Calendar
N	I	In & Out Times / Hrly Rate
N	P	Purchases

# Provider EFT Information

## Banking Information

## Enrollment Process

Service Provider Name

Service Provider Number

Bank Name (Primary Account)

Bank Routing Number (Primary Account)

Account Number (Primary Account)

Account Type (Primary Account)

Service Provider SSN or TIN

Authorized Representative Name

Signature (*typed name accepted*)

Date

By typing your name in the signature box, you certify that the information provided is accurate, complete, and that you agree to the terms outlined in this form.

## Required Attachment

**Please attach a voided check or bank statement that includes the business name, routing number, and account number**

Failure to include all required information could result in delayed processing times. Please allow up to 30 days for EFT setup to be completed.

**For residential providers only:** A second bank account or US Bank Card should be used for receiving Personal & Incidental (P&I) funds for clients. Complete the applicable P&I; EFT or US Bank Card form found in the link below and return it to POS@altaregional.org.

[https://www.altaregional.org/sites/main/files/file-attachments/pi\\_eft\\_or\\_us\\_bank\\_card\\_.pdf?1773756653](https://www.altaregional.org/sites/main/files/file-attachments/pi_eft_or_us_bank_card_.pdf?1773756653)

# Provider Vendor Administrator Security Information

## Enrollment Process

Service Provider Name

Service Provider Number

Administrator Name

Email Address

Telephone Number

Administrator Signature (*typed name accepted*)

Date

By typing your name in the signature box, you certify that the information provided is accurate, complete, and that you agree to the terms outlined in this form.

# Regional Center Provider Electronic Billing Agreement Form

## Terms and Conditions

### 1. Claims Acceptance and Processing

The regional center agrees to accept from the enrolled Provider electronic invoices. The Provider hereby acknowledges that he or she has received and read and understands and agrees to abide by the EB provider manual and its contents, and agrees to read and comply with all EB provider manual updates and provider bulletins relating to electronic billing.

### 2. Claims Certification

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center consumers have been provided to the consumers by the Provider. The services were, to the best of Provider's knowledge, provided in accordance with the consumer's written Individual Program Plan. The Provider shall certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of five years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the consumer. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability. I certify that the consumer(s) submitted through the electronic process were provided the services as authorized for the stated periods, and that no additional charges were made to other parties. These claims are submitted under penalty of perjury in accordance with the Medi-Cal program Provider Agreement Claim Certification.

### 3. Verification of Claims With Source Documents

The Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all invoice information for payment. The Provider shall also assume personal responsibility for verification of submitted invoices with source documents. The Provider agrees that no invoice shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failures to make, maintain, or produce source documents shall be cause for immediate termination of electronic billing privileges.

### 4. Change in Electronic Billing Status

The Provider and the Regional Center agree that any changes in Provider status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

### 5. Provider Reviews

The Provider agrees that agents of the Regional Center, the Department of Developmental Services, the Department of Health Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of invoices submitted electronically.

### 6. Effective Date

This agreement shall become effective upon approval of the Regional Center.

# Regional Center Provider Electronic Billing Agreement Form

## Terms and Conditions

### 7. Termination

The Department, Regional Center or Provider may terminate this agreement with or without cause by giving seven days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department or Regional Center. The Department or Regional Center may, however, terminate this agreement immediately upon determination that the Provider has failed or refused to produce or retain source documents in accordance with federal and state laws or this agreement or has violated other provisions of the provider agreement.

### 8. Provider to Hold Regional Center and State of California Harmless

The provider agrees to hold the Regional Center and the State of California harmless for any and all failures performed by billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The provider agrees that the provider is assuming any and all risks that accompany electronic billing and that the provider is not relying upon the evaluation, if any, that the State of California or Regional Center has made of the electronic billing system or software the provider is using.

### 9. Confidentiality of Record

The Provider agrees to provide adequate precautions to protect the confidentiality of Consumer information in accordance with Welfare and Institutions Code section 4514, Health Insurance Portability and Accountability Act (HIPAA), and all other applicable state and federal statutes and regulations regarding confidentiality of consumer information.

Administrator Name

Title

Email Address

Administrator Signature (*typed name accepted*)

Date

By typing your name in the signature box, you certify that the information provided is accurate, complete, and that you agree to the terms outlined in this form.

Please complete all required fields, then click Submit. If the Submit button does not open your email program, save the completed form and email it to: **pos@altaregional.org**