BILLING & DENIAL RESOLUTION TUTORING LAB

SEPTEMBER 03, 2026

- Reminders & Announcements
  - Annual Void Report
  - New Claim Submission Timeliness Deadlines
- Other Health Coverage (OHC) Billing Guidance
- CO 96 N30 – Women's Health History Denials
- New GD modifier
- CalPM Eligibility Check Widget
- Authorization Requirements for Changes in Coverage
- Tutoring Session: A Look at the Treatment Reimbursements Process
- Billing & Denial Resolution Tutoring Lab Feedback Survey
- Open Q&A

REMINDERS & ANNOUNCEMENTS

REMINDERS

Q&A REMINDER

- As a reminder, to ask questions during this lab, please use one the following:

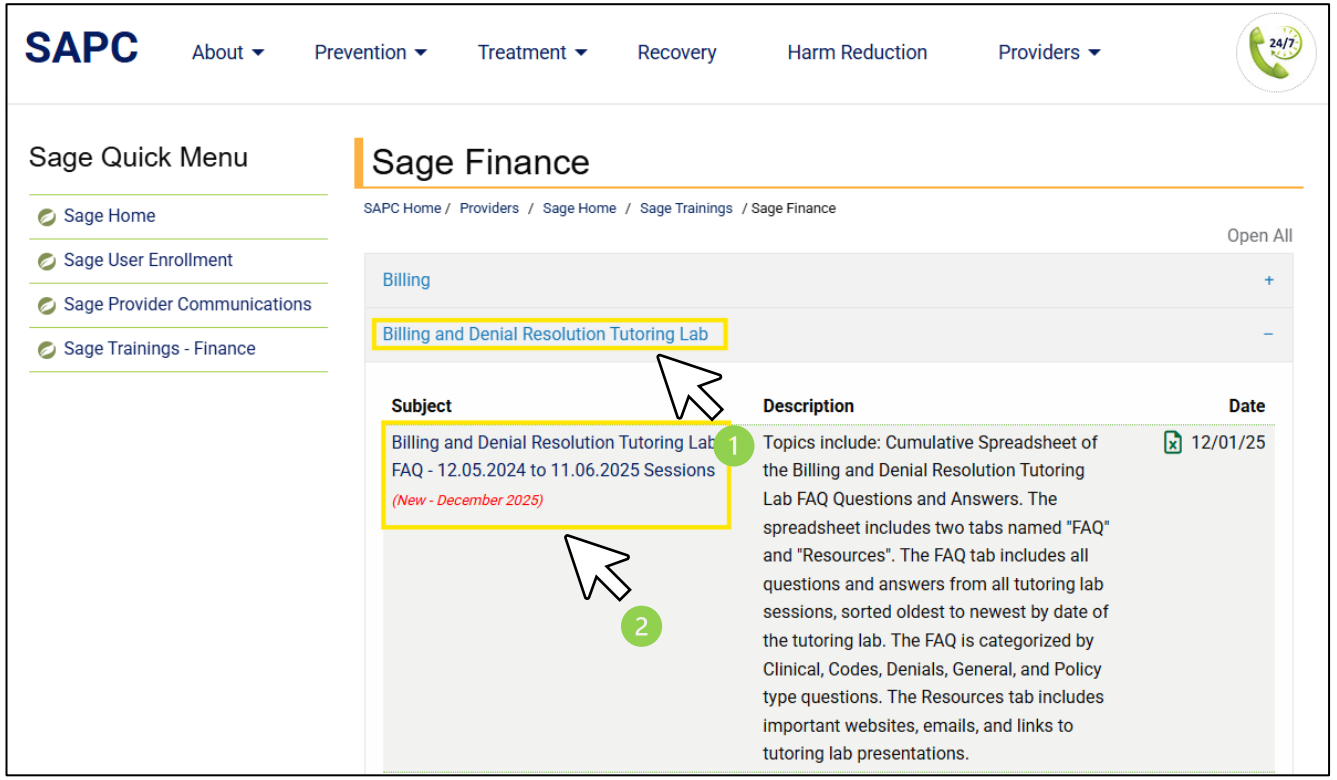
  - Q&A Button

  - Raise Hand Button

FAQ REMINDER

As a reminder, the compiled FAQ from each lab are uploaded monthly. Please check to see if your question has been asked & answered in previous tutoring labs. Find the latest compiled FAQ at*:*
http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm

1. Visit the link above
2. Click on the section named **Billing and Denial Resolution Tutoring Lab**
3. To download an FAQ, click on the link ***Billing and Denial Resolution Tutoring Lab – 12.05.2024 to [Last Lab Date] Sessions***

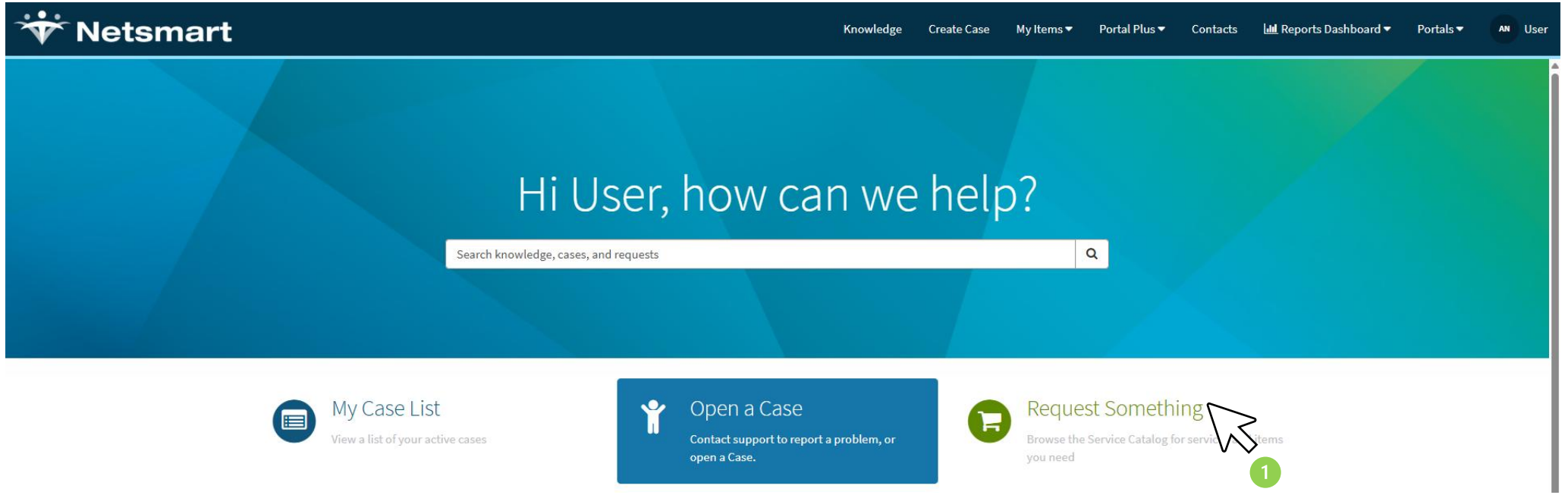


HELP DESK TICKET FORMS

- **Two different forms for Help Desk tickets**
- **ServiceNow Create Case Form**
  - Tickets go directly to Netsmart
  - Use this form to report Sage system issues
- **Request Billing Assistance Form**
  - Ticket goes directly to SAPC Finance
  - Use this form to report billing-related issues
  - Link: https://netsmart.service-now.com/plexussupport?id=sc_cat_item&sys_id=1ac545cf1b115e103001a9b6624bcb00&sysparm_category=4cb69d19c3921200b0449f2974d3ae69
- **Note:** Billing-related tickets submitted through the Create Case form will take longer to resolve

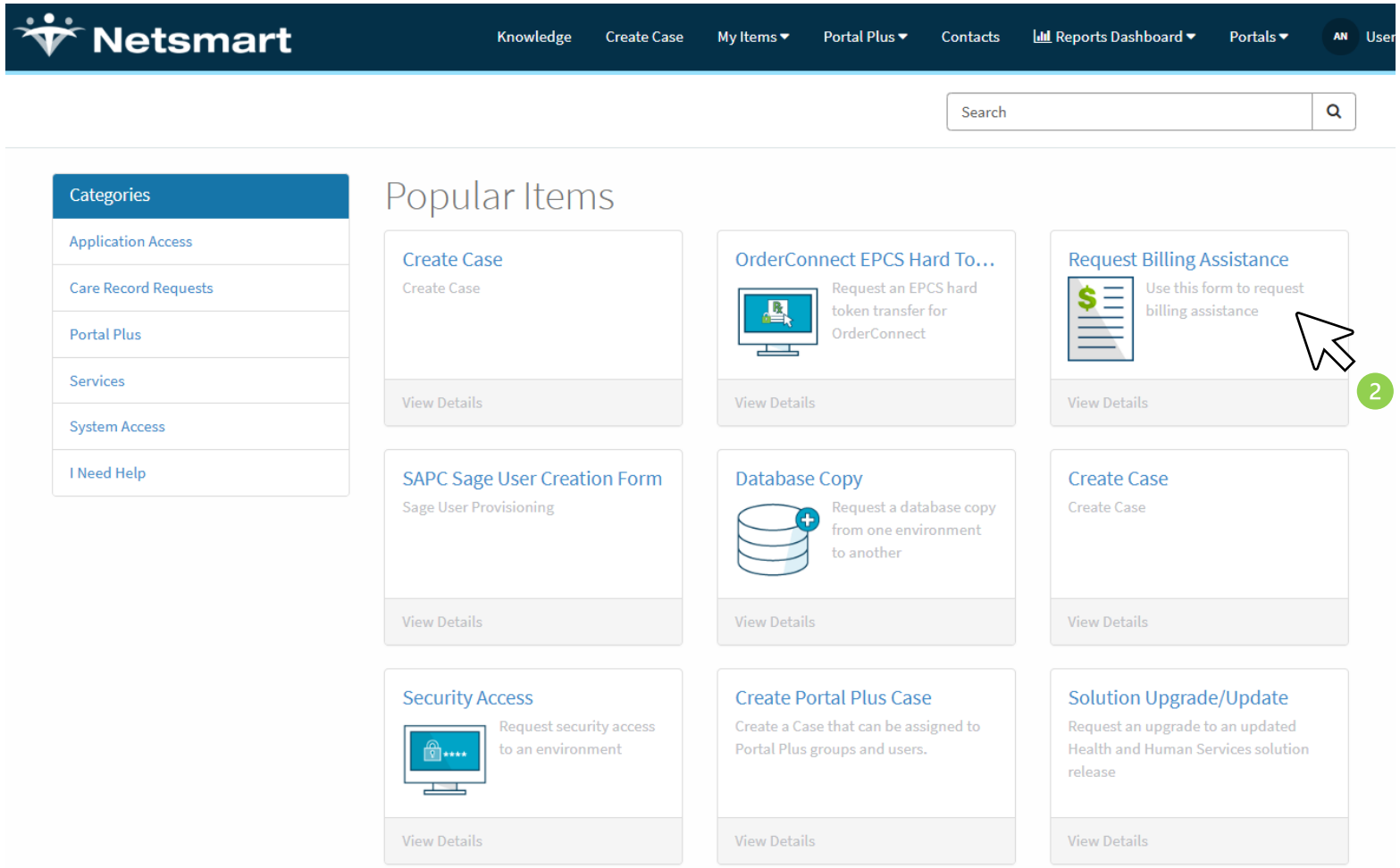
WHERE TO FIND THE REQUEST BILLING ASSISTANCE FORM

- There are two ways to access the Request Billing Assistance form:
  1. Direct Link: Request Billing Assistance **or**
  2. Follow these 2 steps:
     - Step 1: Click **Request Something**



WHERE TO FIND THE REQUEST BILLING ASSISTANCE FORM

- Step 2: Click **Request Billing Assistance**

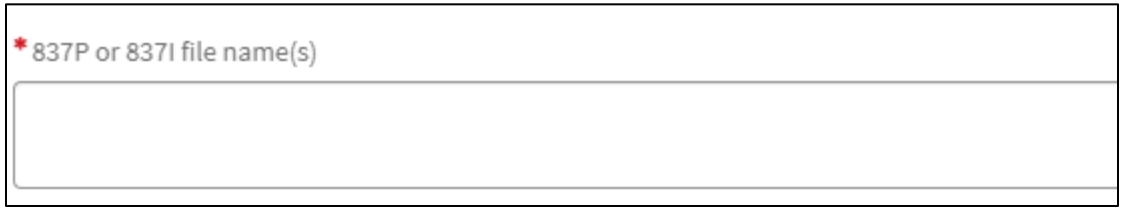


HELP DESK OPERATING HOURS

- SAPC Finance help desk tickets are worked during normal County business hours
  - Monday through Friday, 8AM to 5PM
  - Closed on all federal holidays
  - Any tickets received outside of this time is assigned the next business day
    - i.e. If a ticket is received on a Friday at 6PM, it will be assigned to an analyst on the following Monday

REQUEST BILLING ASSISTANCE FORM – SECONDARY SAGE USERS

- For Secondary Sage Users, there is a field asking for the **837P or 837I file name(s)**



- Please don't enter **837P** in this field, this will delay investigation/resolution of your ticket
- Please provide the actual filename of the 837 file submitted
  - For example:
    - **ADP-1234-837P-07312020-001.txt**
    - **ADP-1234-837I-07312020-001.txt**
    - **ADP-1234-837P-07312020-replacement-001.txt**
    - **ADP-1234-837I-07312020-void-001.txt**

FOLLOW THE RECOMMENDED AGENCY WORKFLOW PRIOR TO OPENING A HELP DESK TICKET

We recommend that a Provider Agency attempts to self-resolve a denial before opening a Help Desk ticket by:

1. Opening the Sage Claim Denial and Resolution Crosswalk Version 5.0
    a. If a State denial, click on the State Denials tab, and look for **CARC/RARC** in **Denial Code** column
    b. If a Local denial, click on the Local Denials tab, and look for **Denial Reason in DMC Description** column
2. Following the resolution steps in the **Cause and Resolution** column
3. If you are unable to fix the issue using the steps above, please open a Help Desk ticket using the Request Billing Assistance form

ANNOUNCEMENTS

ANNUAL VOID REPORT

ANNUAL VOID REPORT - OVERVIEW

- Federal and State requirements require County Behavioral Health Plans to follow the Overpayments Recovery and Report Procedures outlined in DHCS BHIN 19-034.
- The BHIN requires the plans to obtain the reason why a service was voided for both DMC and non-DMC services from contracted providers.
- To meet this requirement SAPC will issue reports to each agency via SFTP in October, where an agency response will be required for each voided service within 4 weeks.
- A future SAPC IN will be issued that describes this requirement for agencies and more information will be shared in the October Tutoring Lab to walk agencies through completing the spreadsheets and the attestation.

NEW CLAIM SUBMISSION TIMELINESS DEADLINES

NEW CLAIM SUBMISSION TIMELINESS DEADLINES

- **Effective January 1, 2027**, provider agencies will be held to the original & replacement claim submission deadlines below across all fiscal years
- Services submitted after these deadlines will be automatically denied by Sage
- What are the new claim submission timeliness deadlines?

Original Claim Submission Deadline: 9 months/270 days from Date of Service

Replacement Claim Submission Deadline: 12 months/365 days from Date of Service

NEW CLAIM SUBMISSION TIMELINESS DEADLINES

Original Claim Submission Deadline: 9 months/270 days from Date of Service

Billable Date of Service (DOS) for Original claims, based on the effective date of 1/1/2027:

Date of Service (DOS)	New Original Claim Submission Deadline	Fiscal Year
7/1/2025 to 4/5/2026	Deadline to submit originals is 12/31/2026	FY 25-26
4/6/2026	**1/1/2027***	FY 25-26
4/7/2026	1/2/2027*	FY 25-26
4/8/2026	1/3/2027*	FY 25-26
4/9/2026	1/4/2027*	FY 25-26
4/10/2026 to 6/30/2026	1/5/2027* to 3/27/2027*	FY 25-26
7/1/2026 to 6/30/2027	3/28/2027* to 3/26/2028*	FY 26-27

*** Based on the formula (Date of Service + 270 days), where each original claim submission deadline date corresponds to a single date of service.**

NEW CLAIM SUBMISSION TIMELINESS DEADLINES

Replacement Claim Submission Deadline: 12 months/365 days from Date of Service

Billable Date of Service (DOS) for Replacement claims, based on the effective date of 1/1/2027:

Date of Service (DOS)	New Replacement Claim Submission Deadline	Fiscal Year
7/1/2025 to 12/31/2026	Deadline to submit replacements is 12/31/2026	FY 25-26
1/1/2026	**1/1/2027***	FY 25-26
1/2/2026	1/2/2027*	FY 25-26
1/3/2026	1/3/2027*	FY 25-26
1/4/2026	1/4/2027*	FY 25-26
1/5/2026 to 6/30/2026	1/5/2027* to 6/30/2027*	FY 25-26
7/1/2026 to 6/30/2027	7/1/2027* to 6/30/2028*	FY 26-27

*** Based on the formula (Date of Service + 365 days), where each replacement claim submission deadline date corresponds to a single date of service.**

NEW CLAIM SUBMISSION TIMELINESS DEADLINES

- Agencies should not delay in the submission of outstanding claim submission nor delay in correcting and resubmitting all Local and State denials by the new claim submission timeliness deadlines.
- SAPC Finance is preparing an Information Notice (IN) to formalize the upcoming claim submission deadlines.

OTHER HEALTH COVERAGE (OHC) BILLING GUIDANCE

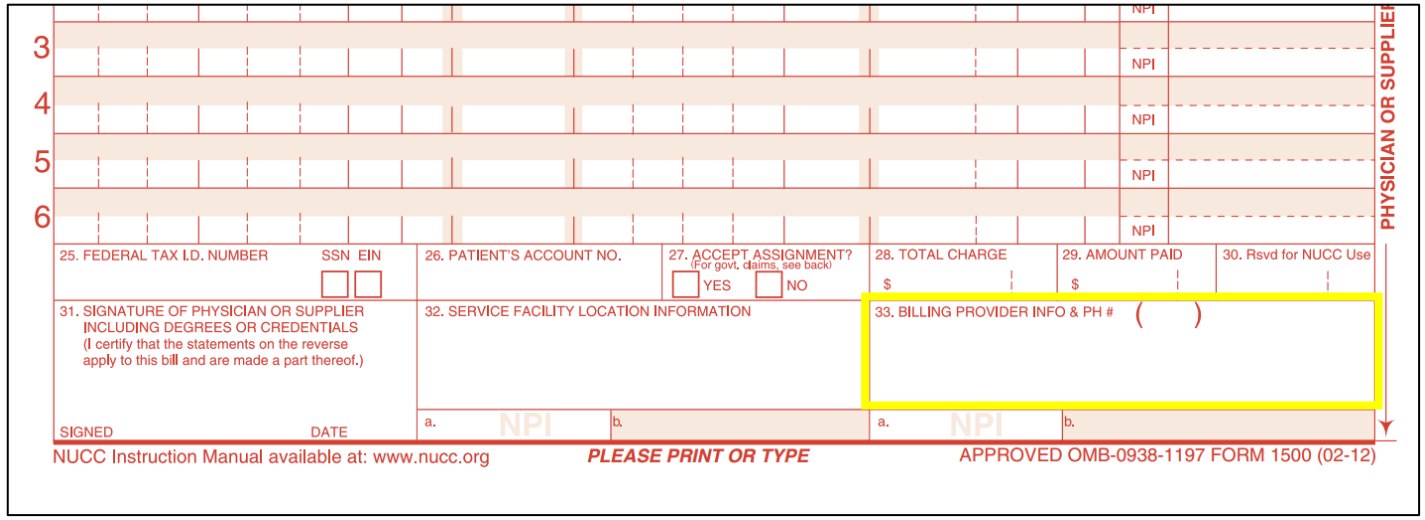
OTHER HEALTH COVERAGE (OHC) BILLING GUIDANCE

- Recently, SAPC has received coverage denial letters from various Other Health Coverage (OHC) insurance plans where SAPC was listed as the billing agency
- Agencies who are billing OHC plans must ensure that SAPC is not anywhere on the claims submitted to the OHC, to ensure that the agency receives the appropriate denial letters and any payments that may result from claim approvals

OTHER HEALTH COVERAGE (OHC) BILLING GUIDANCE

Agencies are advised to follow the steps below when billing OHC insurance plans:

- For agencies who bill via 837 to the OHC insurance plan
  - Ensure Loop 1000A Submitter Name, Loop 2000A Billing Provider Hierarchical Level, and the various 2010 Loops include only the agency's information and does not include SAPC's details
- For agencies who bill via CMS 1500 form to the OHC insurance plan
  - Ensure the "**33. Billing Provider Info & PH #**" field includes only the agency's information and does not include SAPC's details



CO 96 N30 – WOMEN'S HEALTH HISTORY DENIAL

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If you are seeing CO 96 N30 denials on your EOBs, this can be due to the following:

1. The Women's Health History Form was not completed or missing one or more of the following required fields:
   a) Assessment Date
   b) Pregnancy Start Date
   c) Pregnancy End Date (required to bill for postpartum services)
2. A PPW service was billed more than 365 days after the pregnancy end date listed in the Women's Health History Form
3. A Non PPW claim was submitted, and the client's Medi-Cal Aid code is not for full scope Medi-Cal and only covers DMC services for pregnant women.
4. The clients MEDS profile displays and active incarceration

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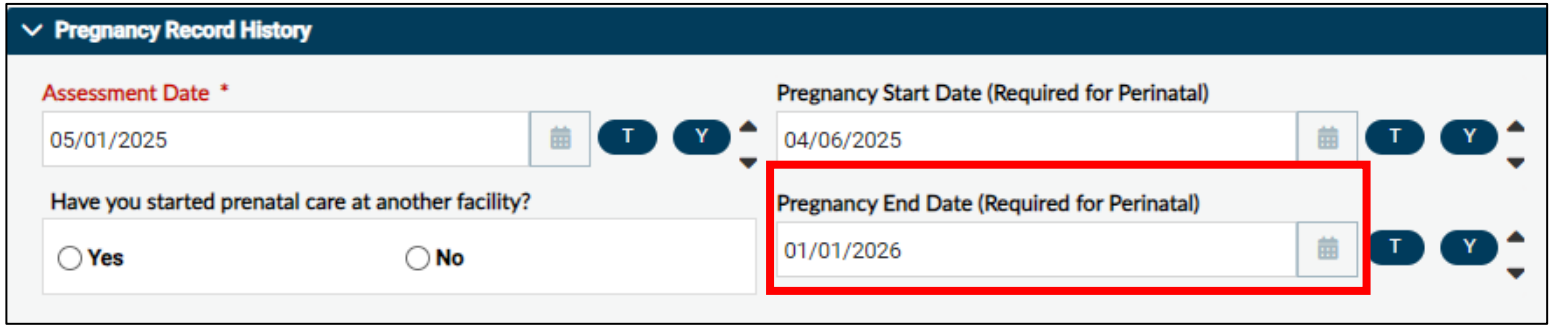
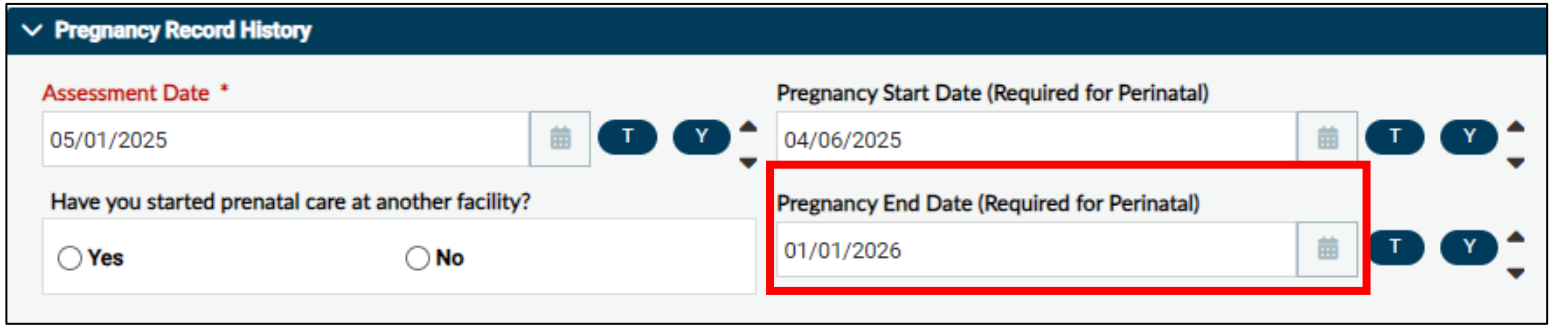
CO 96 N30 – WOMEN'S HEALTH HISTORY DENIAL EXAMPLE



In this example, the Pregnancy End Date is 01/01/2026. With the postpartum period being 365 days from the Pregnancy End Date, this would make the end of postpartum for this client 01/01/2027.

CO 96 N30 – WOMEN'S HEALTH HISTORY DENIAL EXAMPLE



In this example, with a postpartum end date of 01/01/2026, there are two things to keep in mind before billing for this client:

1. If the date of service is between the pregnancy start date and the calculated postpartum end date, continue using a PPW service authorization for billing and the HD modifier.
2. If the date of service is after the postpartum end date, do not use the PPW service authorization anymore. Instead request a new non-PPW service authorization prior to billing, then submit claims without the HD modifier.

NEW GD MODIFIER

NEW GD MODIFIER - BACKGROUND

- Narcotic Treatment Program (NTP) Counseling Unit Threshold and Manual Review (DHCS BHIN 26-022)
  - Due to an audit in 2022 by the Office of Inspector General (OIG), that uncovered errors in NTP counseling claims where an unreasonable number of service units were billed for a single client in one day
  - This DHCS policy establishes an outlier threshold for OTP/NTP individual (H0004), group (H0005), and family counseling (T1006) service units for a single client on a single date of service

NEW GD MODIFIER – ABOUT

- **Effective for dates of service of 9/22/2026 and beyond**
  - GD modifier not required for dates of service before 9/22/2026
- Only applies to OTP levels of care
- Only applies to the following codes
  - H0004:UA:HG (Individual Counseling)
  - H0005:UA:HG (Group Counseling)
  - T1006:UA:HG (Family Counseling)
- If the total number of units across the three codes above is 9 or more, the GD modifier must be used on **ALL** service codes billed for the date of service.

NEW GD MODIFIER – HOW TO BILL ORIGINAL CLAIMS

Code	Code Description	Level of Care	Level of Care Modifier	# of Units	GD modifier required?	Bill this Code
H0004	Behavioral health counseling and therapy, 15 minutes	OTP/NTP	UA:HG	1-8 units	No	H0004:UA:HG
H0005	Alcohol and/or drug services; group counseling by a clinician, 15 minutes	OTP/NTP	UA:HG	1-8 units	No	H0005:UA:HG
T1006	Alcohol and/or substance abuse services, family/couple counseling, 15 minutes	OTP/NTP	UA:HG	1-8 units	No	T1006:UA:HG
H0004	Behavioral health counseling and therapy, 15 minutes	OTP/NTP	UA:HG	**9-16 units**	**Yes**	H0004:UA:HG:**GD**
H0005	Alcohol and/or drug services; group counseling by a clinician, 15 minutes	OTP/NTP	UA:HG	**9-16 units**	**Yes**	H0005:UA:HG:**GD**
T1006	Alcohol and/or substance abuse services, family/couple counseling, 15 minutes	OTP/NTP	UA:HG	**9-16 units**	**Yes**	T1006:UA:HG:**GD**

NEW GD MODIFIER – LOCAL & STATE DENIALS OVERVIEW

Denial Type	Denial Reason	DMC Description	When you'll get this denial	Where you'll see this denial
Local	Currently, Sage is not configured to locally deny erroneous GD modifier claims. However, this might change in the future.			
State	CO 96 N640	Short-Doyle denied this service due to specific claim requirements. The NTP claim submitted contained a total of nine or more combined units. However, the claim did not include the GD modifier, which is necessary when the combined units reach this threshold.	When the GD modifier is **missing** for a service that meets these conditions: • OTP/NTP Level of Care • H0004, H0005, or T1006 • 9-16 units	• "Denial Reason" column in MSO KPI State Denial View • "Retro Reason" column in MSO KPI Payment Reconciliation View • "Retro Reason" columns in the Sage Cost of Service By Client Report • EOB

NEW GD MODIFIER – DENIAL RESOLUTION

Original Code Billed	# of Units Billed	Cause of Denial	Primary/Secondary Sage User Resolution
H0004:UA:HG:GD	1-8 units	GD modifier not required on claim	Since 1-8 units, GD modifier not required. Submit replacement claim with code H0004:UA:HG
H0005:UA:HG:GD	1-8 units	GD modifier not required on claim	Since 1-8 units, GD modifier not required. Submit replacement claim with code H0005:UA:HG
T1006:UA:HG:GD	1-8 units	GD modifier not required on claim	Since 1-8 units, GD modifier not required. Submit replacement claim with code T1006:UA:HG
H0004:UA:HG	9-16 units	GD modifier missing on claim	Since 9-16 units, GD modifier required. Submit replacement claim with code H0004:UA:HG:GD
H0005:UA:HG	9-16 units	GD modifier missing on claim	Since 9-16 units, GD modifier required. Submit replacement claim with code H0005:UA:HG:GD
T1006:UA:HG	9-16 units	GD modifier missing on claim	Since 9-16 units, GD modifier required. Submit replacement claim with code T1006:UA:HG:GD

- **Primary Sage Users:** Submit replacement claims in the Sage Replacement Claim Assignment (CMS-1500) form
- **Secondary Sage Users:** Submit replacement claims in your EHR

NEW GD MODIFIER – KNOWLEDGE CHECK

NEW GD MODIFIER – KNOWLEDGE CHECK #1

Question: A client in **OTP/NTP** attends a 30-minute individual counseling session (**H0004**). The 30-minute session is calculated to be **2 units**. Which code should the agency submit on their treatment claim?

A. H0004:UA:HG
B. H0004:UA:HG:GD
C. H0005:UA:HG
D. H0004:GD

NEW GD MODIFIER – KNOWLEDGE CHECK #1

Question: A client in **OTP/NTP** attends a 30-minute individual counseling session (**H0004**). The 30-minute session is calculated to be **2 units**. Which code should the agency submit on their treatment claim?

A. **H0004:UA:HG**

B. H0004:UA:HG:GD (GD modifier not applicable, only required for 9-16 units)

C. H0005:UA:HG (Wrong procedure code)

D. H0004:GD (UA:HG modifier missing, GD modifier not applicable)

NEW GD MODIFIER – KNOWLEDGE CHECK #2

Question: A client in **OTP/NTP** attends a 240-minute family counseling session (**T1006**). The 240-minute session is calculated to be **16 units**. Which code should the agency submit on their treatment claim?

A. T1006:UA:HG

B. T1006:UA:HG:GD

C. T1006:GD

D. T1006:GD:UA:HG

NEW GD MODIFIER – KNOWLEDGE CHECK #2

Question: A client in **OTP/NTP** attends a 240-minute family counseling session (**T1006**). The 240-minute session is calculated to be **16 units**. Which code should the agency submit on their treatment claim?

A. T1006:UA:HG (Missing GD modifier after UA:HG modifiers)

B. T1006:UA:HG:GD

C. T1006:GD (Missing UA:HG modifiers before GD modifier)

D. T1006:GD:UA:HG (Level of care modifiers UA:HG need to be before GD modifier)

NEW GD MODIFIER – KNOWLEDGE CHECK #3

Question: For OTP/NTP, which of the following codes **is not billable** with the GD modifier?

A. T1006
B. H0005
C. H0050
D. H0004

NEW GD MODIFIER – KNOWLEDGE CHECK #3

Question: For OTP/NTP, which of the following codes **is not billable** with the GD modifier?

A. T1006 (Billable for OTP/NTP with GD modifier)

B. H0005 (Billable for OTP/NTP with GD modifier)

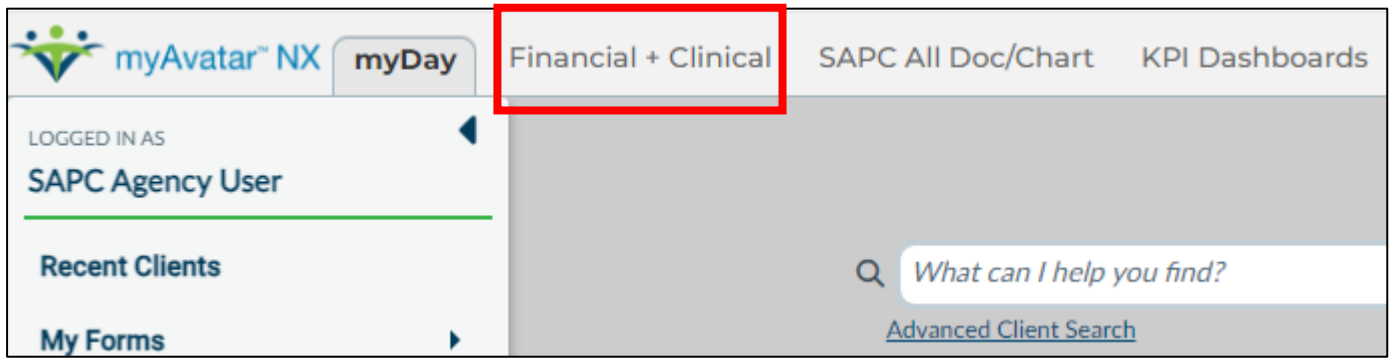
C. H0050 (GD modifier not billable with Contingency Management)

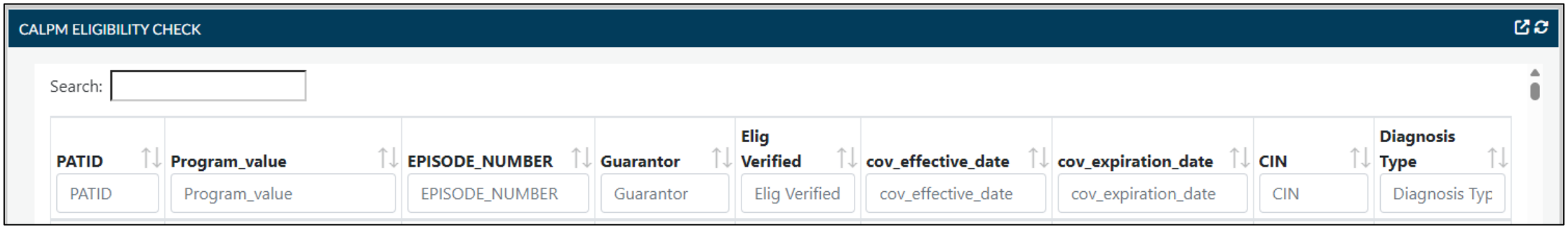
D. H0004 (Billable for OTP/NTP with GD modifier)

CALPM ELIGIBILITY CHECK WIDGET

CALPM ELIGIBILITY CHECK WIDGET

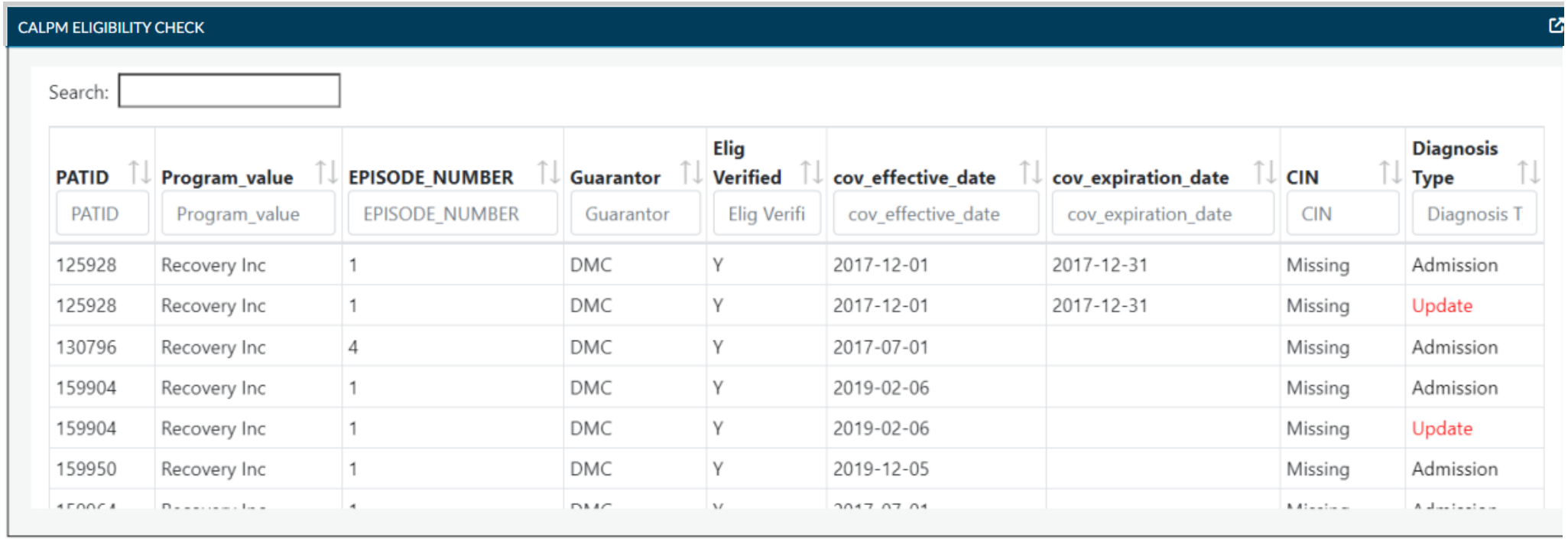
- How do you access the CalPM Eligibility Check widget?





CALPM ELIGIBILITY CHECK WIDGET

- The CALPM Eligibility Check widget populates data for patients with missing or incorrect data on the Financial Eligibility and/or Diagnosis form that may lead to claim denials for “Eligibility Not Found/Verified in CalPM” denials
- Sage checks for certain data elements that are needed to bill Medi-Cal. If those elements are missing, Sage is set to deny those claims locally

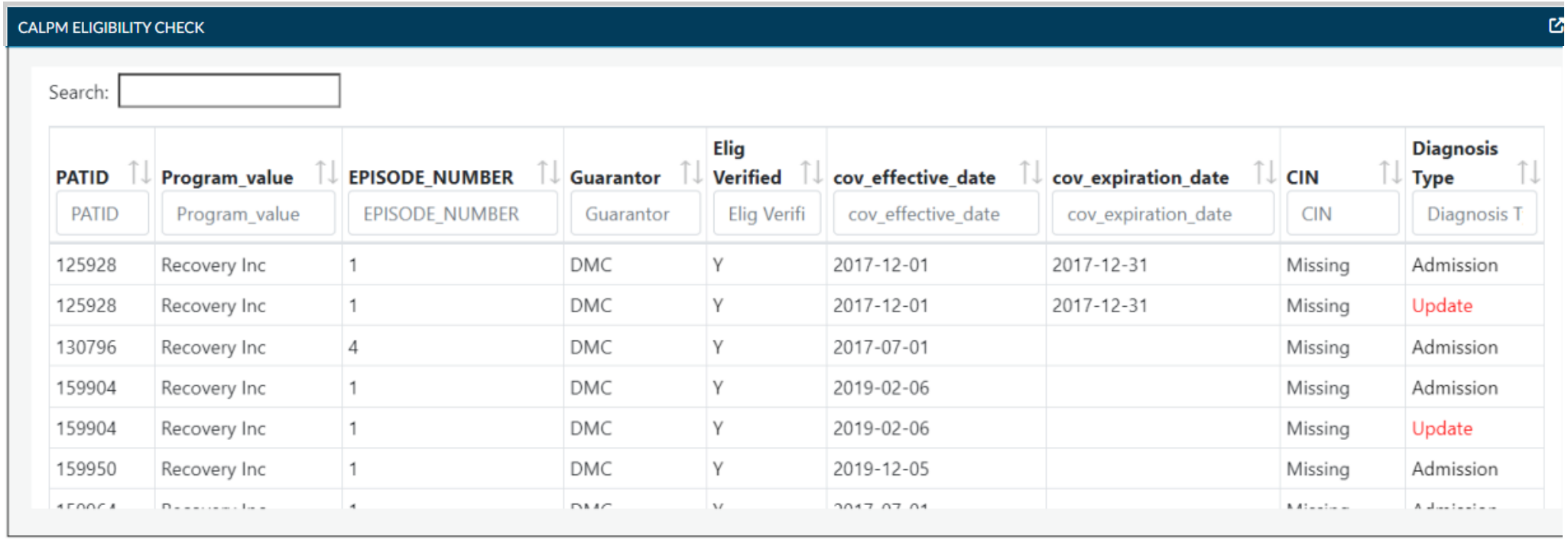


PATID	Program_value	EPISODE_NUMBER	Guarantor	Elig Verified	cov_effective_date	cov_expiration_date	CIN	Diagnosis Type
125928	Recovery Inc	1	DMC	Y	2017-12-01	2017-12-31	Missing	Admission
125928	Recovery Inc	1	DMC	Y	2017-12-01	2017-12-31	Missing	Update
130796	Recovery Inc	4	DMC	Y	2017-07-01		Missing	Admission
159904	Recovery Inc	1	DMC	Y	2019-02-06		Missing	Admission
159904	Recovery Inc	1	DMC	Y	2019-02-06		Missing	Update
159950	Recovery Inc	1	DMC	Y	2019-12-05		Missing	Admission

CALPM ELIGIBILITY CHECK WIDGET

This widget populates the most common errors found in Sage, including:

1. Eligibility Verified is marked “No”
2. Coverage Expiration Date is prior to the date of service
3. Missing CIN on the DMC guarantor


CALPM ELIGIBILITY CHECK

Search:

PATID	Program_value	EPISODE_NUMBER	Guarantor	Elig Verified	cov_effective_date	cov_expiration_date	CIN	Diagnosis Type
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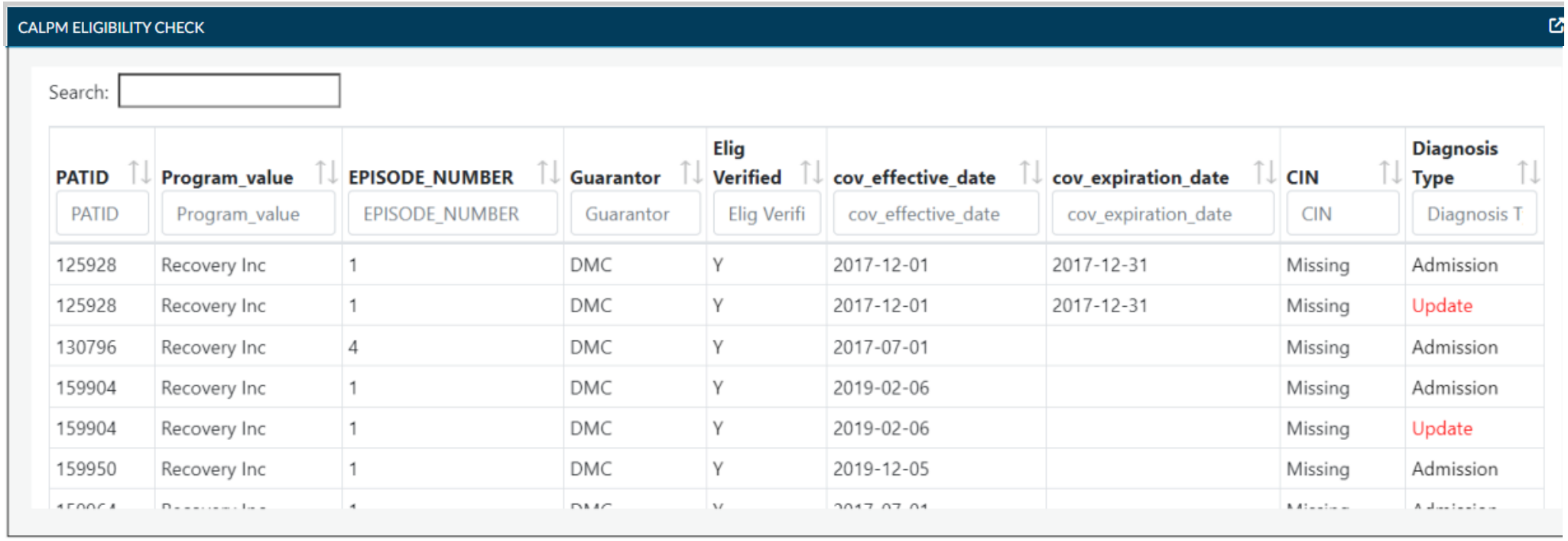
159904	Recovery Inc	1	DMC	Y	2019-02-06		Missing	Update
159950	Recovery Inc	1	DMC	Y	2019-12-05		Missing	Admission

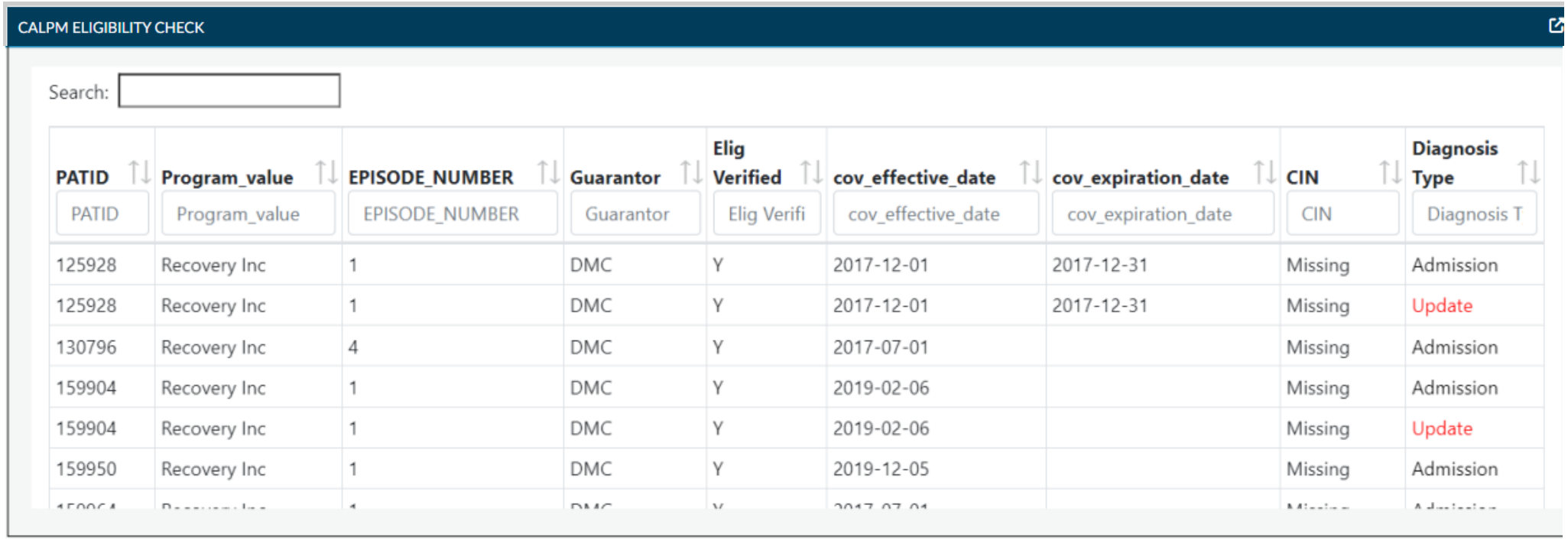
CALPM ELIGIBILITY CHECK WIDGET

- Additionally, the Diagnosis column is added to provide visibility on the current diagnosis type.
- All claims must have an Admission Type of Diagnosis in the record. If this column shows a diagnosis type other than Admission, providers should double check to ensure there is an existing admission diagnosis.
- Update diagnoses are permissible and best practice for each new treatment admission, however, cannot be the only diagnosis on record.



CALPM ELIGIBILITY CHECK WIDGET

- Finally, it is best practice to review this widget before submitting billing to prevent “Eligibility not found/verified in CalPM”, so please remember to add this to your pre-billing workflow!



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AUTHORIZATION REQUIREMENTS FOR CHANGES IN COVERAGE

UPDATED GUIDANCE – AUTHORIZATION REQUIREMENTS FOR CHANGES IN COVERAGE

Original Service Authorization Funding Source	DMC Coverage	Non-DMC Coverage	CIFP Coverage	New Service Authorization Required Prior to Billing for Services?	What to Do Before Submitting Claims
Non-DMC	Client gains DMC coverage	Client has Non-DMC coverage	-	**Yes**	Request a new service authorization with DMC funding source
DMC	Client loses DMC coverage	Client has Non-DMC coverage	-	**Yes**	Request a new service authorization with Non-DMC funding source
DMC	Client loses DMC coverage	Client gains Non-DMC coverage	-	**Yes**	Request a new service authorization with Non-DMC funding source
DMC	Client loses DMC coverage	-	Client gains CIFP coverage	**No**	Use existing DMC service authorization for CIFP
Non-DMC	-	Client loses Non-DMC coverage	Client gains CIFP coverage	**No**	Use existing Non-DMC service authorization for CIFP
DMC	Client loses DMC coverage	Client loses Non-DMC coverage	Client gains CIFP coverage	**No**	Use existing DMC service authorizations for CIFP
Non-DMC	Client gains DMC coverage	-	Client loses CIFP coverage	**Yes**	Request a new service authorization with DMC funding source

TUTORING SESSION: A LOOK AT THE TREATMENT REIMBURSEMENTS PROCESS

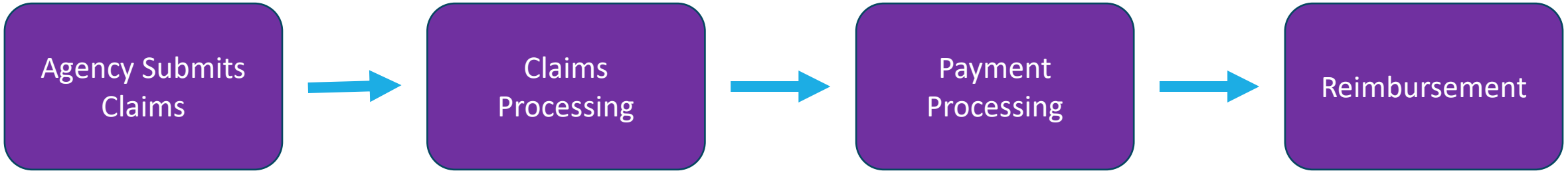
AGENDA

- Overview
- Claim Submission Deadlines for Payment Processing & Payment Timelines
- Payment Processing
- Things that Affect the Final Check Amount
- Sample RA

OVERVIEW

There are many factors that can affect an Agency's billed treatment reimbursements. This tutoring session will provide a walkthrough on what happens from the time a claim is submitted to when an Agency receives an RA in the SFTP after receiving payment.

OVERVIEW

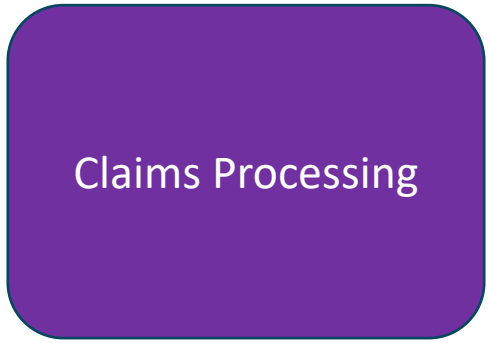

Agency Submits Claims
Claims Processing
Payment Processing
Reimbursement

CLAIM SUBMISSION DEADLINES FOR PAYMENT PROCESSING & PAYMENT TIMELINES

Agency Submits Claims

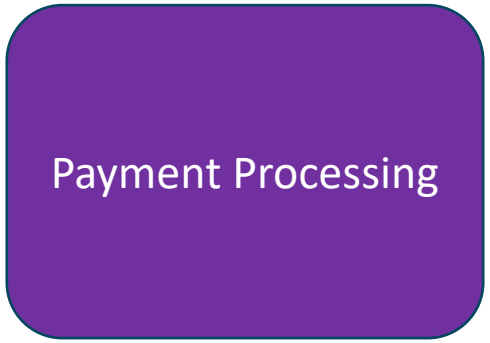
- If claims are submitted on or before the 10th of each month, payment can be anticipated around the 25th of that month
- Any claims submitted after the 10th may not be included in that month's payment cycle

CLAIMS PROCESSING & EOB TIMING



- After claims are submitted, they are then adjudicated in Sage, generating EOBs that contain the claim adjudication results (approve/deny)
  - EOBs generate at 9PM for all agencies, however for -
    - Primary Sage Users: any claims submitted after 9PM will generate an EOB the following business day at 9PM
    - Secondary Sage Users: any claims submitted after 9PM will generate an EOB the following calendar day at 9PM

PAYMENT PROCESSING



- After the EOBs are generated, this is when the SAPC payment processing begins
- SAPC utilizes generated EOBs to determine -
  - What to pay and how much
  - What to recoup
- After payment is disbursed, an RA is sent via SFTP, outlining the details of the payment(s) received

WHAT AFFECTS THE FINAL CHECK AMOUNT

- While you may have submitted treatment claims that were 100% approved, the check amount could still be affected by the following:
  - Current Year & Prior Year State Denials
  - Voids
  - A/R Recoupments such as Transitional Payments, Cost Reporting
- Disclaimer: Total Expected Disbursements ≠ Actually Paid

SAMPLE RA

Now let’s take a look at a sample RA!

BILLING & DENIAL RESOLUTION TUTORING LAB FEEDBACK SURVEY

BILLING & DENIAL RESOLUTION TUTORING LAB FEEDBACK SURVEY

Please take 5 minutes to complete the short survey linked below:

https://forms.cloud.microsoft/g/GPTi7jDEsk

OPEN Q&A

NEXT BILLING AND DENIAL RESOLUTION TUTORING LAB

The next Billing & Denial Resolution Tutoring Lab will be:

October 8, 2026

1:00 PM to 2:30 PM

AGENCY QUESTIONS

SUBMIT YOUR QUESTIONS!

If you would like to submit your own questions to be answered in the next tutoring lab,

send an email to SAPC-Finance@ph.lacounty.gov

HELPFUL CONTACTS

HELPFUL CONTACTS

Unit/Branch Contact	Email *Do not send Protected Health Information (PHI) to any SAPC email*	Description of when to contact
Sage Helpdesk	**Phone Number:** (855) 346-2392 **ServiceNow Portal:** https://Netsmart.service-now.com/plexussupport	Sage related questions, including system errors, medical record modifications
Sage Management Division (SMD)	SAGE@ph.lacounty.gov	Sage process, workflow, general questions about Sage forms and usage
QI and UM	SAPC.QI.UM@ph.lacounty.gov	All authorization related questions, questions for the office of the Medical Director, medical necessity, secondary EHR form approval
Systems of Care (SOC)	SAPC-SOC@ph.lacounty.gov	Questions about policy, the provider manual, bulletins, and special populations (youth, PPW, criminal justice, homeless)
Health Outcomes and Data Analytics (HODA)	hoda_caloms@ph.lacounty.gov	All questions regarding Sage CalOMS: CalOMS submissions guidelines, issues related to CalOMS forms and submissions in Sage, Data Quality Report, and requests for trainings
Contracts	SAPCMonitoring@ph.lacounty.gov	Questions about general contracts, amendments, appeals, complaints, grievances and/or adverse events. Agency specific contract questions (i.e. Augmentations) should be directed to the agency CPA
Strategic and Network Development	SUDTransformation@ph.lacounty.gov	DHCS policy, DMC-ODS general questions, SBAT
Clinical Standards and Training (CST)	Dsapc.cst@ph.lacounty.gov	Clinical training questions, documentation guidelines, requests for clinical trainings
Finance	Sapc-Finance@ph.lacounty.gov	General questions related to billing. For specific questions related to billing denials, payments, and technical assistance, please open a ticket with the Request Billing Assistance form
Eligibility	DPH-SAPC-EST@ph.lacounty.gov	For any eligibility related questions such as for assistance identifying County of residence, help with the intercounty transfer (ICT) process, applying for Medi-Cal benefits