

GOOD CAUSE CERTIFICATION

_____ requests a waiver of the 30-day Drug Medi-Cal billing limitation for the claims listed below.

COUNTY/DIRECT PROVIDER _____

Delay Reason Code: _____

EDI File Name: _____

CLAIM SUBMITTER'S IDENTIFIER	CLAIM FOR MO/YR	CLAIM SUBMITTER'S IDENTIFIER	CLAIM FOR MO/YR

Signature: COUNTY/DIRECT PROVIDER REPRESENTATIVE

Date:

Phone Number

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STATE USE ONLY

REVIEWED AND APPROVED FOR DELAY REASON CODES 4 AND 11

Analyst Name: _____

Signature: DHCS - FMAB-SUD MANAGER