County of San Diego
County Medical Services (CMS) Program

Provider Handbook
August 2022
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Section 1 County Medical Services Program

The San Diego County Medical Services (CMS) Program is not health insurance; it is the program of last resort for eligible adults, which covers only necessary medical services as outlined in the CMS Medical Policies.

The CMS Program is managed for the County of San Diego by an Administrative Services Organization (ASO), AmeriChoice. Medical services are provided by Community Health Centers, specialist physicians, and hospitals, which contract with the County of San Diego, Health and Human Services Agency. A list of participating primary care providers and hospitals can be found in Attachment A. Patient services, appeals, authorizations, claims processing and payment are handled by AmeriChoice. Any physician who accepts an authorization to see a certified patient is paid at CMS reimbursement rates. The following services are available to County Medical Services (CMS) Program certified patients:

- **Primary Care Services**: No authorization is needed when primary care services are provided by a contracted Community Health Center.
- **Emergency Department Services**: Coverage for an emergency encounter is limited to health services for a physical health condition as the primary reason for the visit. Claims from any San Diego County hospital will be honored for the CMS certified patient presenting for a covered service.
- **Emergency Admissions**: AmeriChoice provides a single authorization number to the hospital for all services associated with the hospital stay, including physician services. This authorization includes one follow-up visit with the attending physician within thirty (30) calendar days of discharge. Additional visits and/or services require authorization from AmeriChoice.
- **Scheduled Admissions**: The admitting physician must obtain prior authorization from AmeriChoice. Approval is based on CMS scope of services and medical necessity.
- **Supplemental Services**: Providers may authorize limited, non-clinic diagnostic procedures and supplies.

**Accessing More Information on the CMS Program**

The following link can be used for accessing CMS Program information:  
http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

Questions and concerns about the operations of this program should be directed to:  
AmeriChoice  
CMS Program Provider Relations  
PO Box 927110  
San Diego, CA 92192  
(800) 587–8118,  
Option 5
Important Numbers

AmeriChoice Numbers and Addresses

CMS Provider Line (Authorizations, Program Information) ...................... (800) 587–8118
CMS Provider Fax (Authorizations, Utilization Review) ......................... (855) 394–7927
CMS Provider Claims (Claims/Payments) ......................................... Email: COSD_claims@uhc.com
........................................................................................................ Fax: (855) 394–7927
AmeriChoice Program Operations .................................................... (888) 595–6547
CMS/AmeriChoice Fax Number ....................................................... (855) 394–7927
CMS/AmeriChoice Address: .............................................................. PO Box 927110
................................................................................................. San Diego, CA 92192

County Administration Numbers and Addresses

CMS Program Administration Phone .................................................. (619) 338–2876
CMS Program Administration Fax .................................................... (619) 338–2972
CMS Program Administration Address .................................. 1255 Imperial Avenue, Suite 446
................................................................................................. San Diego, CA 92101
Compliance Office (to report provider fraud, waste, and abuse) ........ (619) 515–4246
Privacy Office ................................................................................ (619) 515–4243
Access ........................................................................................... (866) 262–9881 or
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/ssp/access.html
Section 2 Eligibility

To be eligible for CMS services, patient must:

- Have an immediate or chronic health condition
- Be a US citizen or eligible alien
- Be a resident of San Diego County
- Be 21 through 64 years old
- Not be linked to Medi-Cal (aged, blind, CalWORKs or disabled)
- Be within CMS income limits or receive General Relief
- Be within CMS resource limits
- Sign a lien and reimbursement agreement for services covered by CMS

Financial Criteria

Financial eligibility criteria for the CMS Program are based on resources and income. Resources include, but are not limited to cash, funds in checking and savings accounts, and real property other than the patient’s primary home.

Citizenship/Eligible Non-Citizen Status

Patients must have U.S. Citizenship or eligible non-citizen status and must provide verification before certification.

Residency

Patients must live in a primary residence located in San Diego County and must provide verification of residence before certification. A fixed address is not required. Patients living on the streets or in a vehicle can be county residents. Patients “visiting” from other counties, states, or countries are not eligible.

Eligibility Appointments

Human Services Specialists (HSSs) are County employees responsible for determining CMS eligibility. Eligibility appointments with HSSs are scheduled by calling (800) 587-8118. Eligibility appointments with HSSs at the hospitals are scheduled by hospital staff or the Hospital and Community Support Services (HCSS) HSS.

CMS Eligibility

Patients apply for standard eligibility by completing an application and providing verifications to an HSS. The HSS reviews the application and verifications and makes the decision to approve or deny. If approved, a Notice of Action (NOA) along with a CMS ID card and Patient Handbook will be mailed to the patient. Patients are approved for a period of up to 6 months. Upon renewal, patients with asthma, diabetes and/or hypertension may be approved eligibility for up to twelve (12) months.
Patients receiving General Relief (GR) are referred to apply for Medi-Cal. If eligible for Medi-Cal, the applicant must complete the appropriate application. If the applicant is not eligible for Medi-Cal, then they may be eligible for CMS.

**CMS Hardship**

An individual whose family income is over 165% FPL, up to and including 350% FPL, and who meets all other CMS eligibility criteria, will be evaluated for a CMS Hardship. CMS Hardship may result in the individual being required to pay or be obligated to pay a monthly Share of Cost (SOC). CMS Hardship applications are evaluated by the County of San Diego.

**Immediate Care**

When a non-certified patient requires *immediate* medical care that the clinic cannot provide, the patient should call the CMS Patient Information Line (800) 587–8118. The Administrative Services Organization (ASO) will evaluate the patient’s medical need and if all CMS criteria are met, the AmeriChoice representative will contact the County Eligibility Unit to schedule an urgent eligibility appointment. Following notification of approved eligibility, AmeriChoice will arrange and authorize appropriate care.

**Emergency Room Care**

When a non-certified patient has received treatment in an emergency room and is treated (including observation) and released in excess of 24 hours, the patient must call the CMS Patient Information Line (800) 587–8118 within 30 calendar days of the uncertified visit to apply for CMS coverage effective the first of the month of the uncertified visit. The patient should notify the customer service representative that they were treated in an emergency room and provide the date that the treatment took place. The patient will be required to provide documentation to verify the emergency room service date.

**Inpatient Care**

When a non-certified patient is admitted to the hospital through the emergency room for less than 24 hours, the patient must call the CMS Patient Information Line (800) 587–8118 within 30 days of the uncertified visit to apply for CMS coverage effective the first of the month of the uncertified visit. The patient should notify the customer service representative that they were hospitalized and provide the date that the treatment took place. The patient will be required to provide documentation to verify the date they were hospitalized.

**Scheduled Admissions and Outpatient Care**

When a non-certified patient has been scheduled for an admission or outpatient service, the patient should call the CMS Patient Information Line at (800) 587–8118. The patient should inform the customer service representative of the date of the scheduled service. AmeriChoice
will evaluate the patient’s medical need and if all CMS criteria are met, AmeriChoice will contact the County Eligibility Unit to schedule an urgent eligibility appointment. Following notification of approved eligibility, AmeriChoice will arrange and authorize appropriate care.

**CMS Identification Card**

CMS patients will receive a white CMS Identification Card and Notice of Action (NOA). The ID card and NOA are not verifications of eligibility and do not authorize services. Eligibility for patients who applied for CMS after May 12, 2008, should be verified on the CMS IT System website: [www.sdcms pov.com](http://www.sdcms pov.com)

Example of the CMS Card is shown below:

White card: Front

[Image of CMS card front]

COUNTY OF SAN DIEGO
COUNTY MEDICAL SERVICES
P.O. BOX 85222
SAN DIEGO, CA 92186-5222
Phone (800)587-8118

Name: John Smith
Member ID #: AB-123-987
Medical Home (PCC): Ocean Clinic
PCC phone #

Eligibility Verification: [www.sdcms pov.com](http://www.sdcms pov.com)

Back

1. If you have a medical need, call your primary care clinic. They can provide or arrange for the care you need.
2. If you have a medical emergency, go to an Emergency Room or dial 911.
3. All services, except community clinic and emergency room visits, must be approved in advance by the CMS Program.
4. If you alter or misuse this card, falsify information, or stop meeting CMS requirements, your eligibility may stop before the thru date. Legal action may be taken if you use this card after loss of eligibility.
5. You must use all other health insurance before CMS.

Other Insurance:

Patient’s Signature:

**Fraud Referral**

When you suspect that a patient is not eligible for CMS, you should call the Patient/Provider Coordinator at (888) 595–6547. You should be able to give the patient’s name, address, birth date, and Social Security number and the reason you suspect fraud. You can remain anonymous.
Section 3 Medical Policy and Scope of Services

Policy
The County Medical Services (CMS) Program is a medical assistance program servicing indigent adult residents of San Diego County. CMS provides physical health services for acute and chronic health conditions. It is the policy of the CMS program to provide coverage for physical health services when program medical criteria are met. The CMS Medical Director can deny coverage if established program medical criteria are not met. The provider or the patient has the right to appeal any CMS Program decision that denies a physical health service.

Mental Health Services for adult indigent residents of San Diego County are provided by the County Mental Health Services Division (Hotline Phone Number: 1–888–724–7240).

The following provides a general overview of the CMS program medical criteria and covered services:

Medical Criteria
Medical criteria are used to determine whether the CMS program will cover a service or treatment. Nationally accepted guidelines, such as MCG (formerly known as Milliman Care Guidelines) are used to help define medical necessity. The CMS program will provide coverage for medical care for an eligible patient whose health condition or symptoms meet the following general criteria:

- **Life-Threatening**
  Major trauma, myocardial infarction (MI), malignant lesions or tumors, cerebral vascular accidents (CVA), etc.

- **Acute**
  Conditions that could lead to medical complications or disability such as benign tumors, fractures, gallbladder and ulcer disease, and infectious diseases, etc.

- **Chronic**
  Conditions that are progressive and require ongoing medical and/or pharmaceutical management such as diabetes, hypertension, asthma, rheumatoid arthritis, etc.

Covered Services
Services covered by the CMS program that do not require prior authorization:

- Evaluation by a primary care provider to determine the nature and severity of a condition and to order treatment
- Follow-up care by a primary care provider for serious or chronic health conditions
- Emergency room care for physical health conditions
- Emergency hospital admissions for physical health conditions
- Emergency medical transportation for physical health conditions
- Emergency dental care
- Formulary medications. All prescriptions funded by CMS must be approved by the Food and Drug Administration (FDA) for that indication.
Services covered only with prior authorization by the CMS program:

- Services provided by a specialist
- Scheduled hospital admissions
- Surgical and diagnostic procedures, including those such as diagnostic mammography and colonoscopy for medical indications such as breast mass or melana
- Limited rehabilitation, medical equipment, and home health services
- Non-emergency medical transportation
- Optometry exams and supplies
- Non-formulary prescription medications

**Not Covered Services**

The following services/diagnoses are NEVER covered:

- Pregnancy and all prenatal care
- Preventive Services, including screening of asymptomatic persons for breast, cervical, prostate and colon cancer.
- Family Planning
- Infertility services
- Sterilization procedures
- Treatment of Erectile Dysfunction
- Mental Health services
- Drug and Alcohol Treatment
- Chiropractic care
- Organ and bone transplants, including bone marrow transplants and all services related to obtaining a transplant
- Any procedure or treatment that is not FDA approved for that indication, such as Experimental Procedures
- Services that are solely intended for Cosmetic purposes, in the absence of trauma or significant pathology
- Medications and services associated with transgender procedures and on-going transgender care
- Non-emergency dental and vision care
- Routine, preventive, school or work examinations or the completion of such forms or certificates
- Orthodontia
- Non-prescription medications
- Emergency room visits for after care, follow-up, and to obtain prescriptions.
- Medical or Clinical trials, including any medication, treatment, procedure, or professional component related to any clinical trial in which the CMS patient may be involved.

* This list is not exhaustive of all Non-Covered Services. Please contact the Service Provider Line at (858) 658-8650 for more information.
Preventive Care

Patients who are receiving primary care and are diagnosed with long-term, chronic conditions are eligible to receive selected preventive services. Services may include but are not limited to annual ophthalmology and podiatry evaluation for persons with diabetics.

Stable Long Standing and/or Congenital Conditions

When a condition is not acute or there is no change in the status of the condition, specialty care will NOT be covered if the condition does not meet medical necessity criteria. Patients may continue to receive care from their primary care provider as needed. Example conditions are:

- Perforated ear drum without history of recent infection
- Nasal fractures (greater than 6 months)

Limited Ancillary Health Services and Supplies

- Home health services for suture removal are covered only when the patients’ physical condition renders them “home-bound.”
- Custom orthotics are rarely approved. Over-the-counter products may be covered with a prescription if they meet medical necessity criteria.
- Dentures – full mouth or anterior stay plate may be covered if enrollee meets medical necessity criteria.
- Optometry services – eye exams and glasses
  - Best visual acuity (with current prescription) is 20/50 or less
  - Patient must have a chronic health condition that requires ongoing treatment or monitoring by the primary care physician

Second Opinion

AmeriChoice will authorize a request for a second opinion for the patient or provider, or AmeriChoice may request a second opinion when any one of the following circumstances are present:

- A more cost-effective treatment option is available.
- Conservative therapy has not been attempted or has not had sufficient time to show results.
- The provider or patient disagrees with the diagnosis and/or the plan of treatment recommended by the specialist.
- The provider or patient is seeking an alternate treatment option that may improve the outcome.
- Patient/provider relationship is hindered.
- Geographic and/or other obstacles prohibit patient from accessing care.

Case Management

The physician may request assistance or case management for the patient, if appropriate and beneficial by calling AmeriChoice, ASO at (858) 658-8650.
Section 4 Prescription Medications

The CMS Program covers prescriptions and pharmaceutical products listed in the CMS Drug Formulary listing. All prescriptions funded by CMS must be approved by the Federal Food and Drug Administration (FDA). In addition to the list of covered pharmaceutical products, the introduction explains general coverage regulations and directions for requesting authorization for non-formulary prescriptions.

Prescriptions

- CMS patients receive approved medications at no cost
- All prescriptions must be filled at participating pharmacies
- Pharmacies may dispense up to a maximum of a ninety (90) day supply for specified medications in the CMS formulary
- The CMS Program Drug Formulary Listing is updated periodically. It is available to be viewed on the CMS website

Formulary Exclusions

Drugs and drug types excluded from the CMS Program Drug Formulary Listing are:

- Birth control products and medications for non-pathologic reasons
- Psychotropic and psychotherapeutic medications prescribed only for mental health conditions
- Experimental drugs or drugs used in an experimental manner
- Nicotine and smoking cessation products
- Medications for the treatment of Erectile Dysfunction
- Medications for transgender conditions

Other Products

Contact a CMS Authorization Representative at (858) 658–8650 to request authorization of durable medical equipment, wound supplies, or nutritional supplements.

Prior Authorization Process

Requests for non-formulary medication require completion the CMS Drug Prior Authorization Request form, which requires medical justification from the physician as to why a formulary alternative is not appropriate.

To obtain authorization of a non-formulary medication, complete the CMS Drug Prior Authorization Request form and fax the request to:

OptumRx, the CMS Pharmacy Benefit Manager:
   Phone: (800) 880–1188
   Fax: (844) 403–1029
Section 5 Prior Authorizations and Physician Responsibilities

The CMS Program reimburses providers for services provided when the patient has been certified for CMS **AND** the services received prior authorization. The physician’s office is responsible for:

• Verifying that the patient is certified for the CMS Program
• Verifying that non-emergent services to be provided to the patient have received prior authorization by the CMS Program
• Submitting a plan of treatment
• Assuring prior authorization for continued treatment and/or referrals
• Submitting claims in the format and time frame required by the CMS Program
Section 6 Primary Care Clinics

During the application process, patients are asked to select a "medical home" where they will receive their primary medical care. Authorization is not needed for visits to the patient’s primary clinic; however, health conditions must be within the CMS Scope of Services.

The Primary Clinic is also responsible for completing the paperwork for their established patients who are applying for General Relief, State Disability and Social Security Disability. Patients must be receiving care for the stated condition either directly from the primary provider or a referred to specialist. A visit for the sole purpose of completing a form is not an approved visit and receives no compensation from the CMS Program.

A primary care visit always includes:

- A face-to-face encounter with a physician or mid-level provider for the purpose of examination, diagnosis, and treatment of the presenting or chronic medical condition. Primary care providers are employed by the clinic and practice in family or general medicine, internal medicine, or gynecology.
- All nursing and supportive services, supplies and equipment provided during the encounter.
- Nutritional counseling and health education are not reimbursed separately but may be covered by other programs.

Primary care visit may include:

- Diagnostic laboratory tests customarily done by the clinic during a primary care visit
- Plain radiographs (2 view films)
- Simple procedures (injections, vision, hearing tests, and EKG)

Dental Services

Limited dental services are available to patients with standard eligibility. Services are limited to procedures described in the listing of CMS Primary Care Basic Dental Services located in Attachment B.

Optometry Services

Optometrist services for refractory exam, lenses and frames are limited to certified patients whose corrected visual acuity is 20/50 or less in one or both eyes. Prior authorization from AmeriChoice is required for all optometry services. Claims history and diagnoses are reviewed to determine criteria for ongoing care.
Section 7 Inpatient and Emergency Department Services

Inpatient Services

Inpatient services are services provided to a patient who is admitted to a hospital as an inpatient and receives medical services from a physician. CMS contracting hospitals are required to notify AmeriChoice within twenty-four (24) hours (extended to the first day following a weekend or holiday) of any admission of a CMS (or potential CMS) patient. For more information on how a potentially eligible CMS patient may apply for CMS coverage of the inpatient service, please refer to Section II of this handbook. Physicians who have treated a CMS certified patient on an emergency inpatient basis will be paid for these services with an approved admission. Inpatient and emergency services at facilities outside of San Diego County are not covered.

- A single authorization number is provided to the hospital for all facility and physician services provided during that hospital stay.
- Authorizations for emergency admissions are processed and approved only when eligibility is confirmed. Authorization numbers are not released until the eligibility process is complete.

Scheduled Admissions and Outpatient Surgery

Outpatient services are services provided to a patient who has been registered or accepted for care but not formally admitted as an inpatient and who does not remain hospitalized over 24 hours. Scheduled, non-emergent admissions and outpatient surgical procedures must receive prior authorization by submitting a Treatment Authorization Request to AmeriChoice. AmeriChoice sends written confirmation to both the ordering physician and the facility that indicates the approved procedure(s) and the valid dates for service. Prior approval includes pre-operative diagnostic tests for scheduled surgical admissions and outpatient surgery. These procedures must be provided during the approved period. For information on how a potentially eligible CMS patient may apply for CMS coverage of the outpatient or emergency department service, please refer to Section II of this handbook.

Emergency Room (ER) Services

Approved emergency services must meet the following conditions:

- The patient must be CMS certified
  - The ER and associated services are covered for CMS certified patients (CMS cardholders) at both contracted and in county non-contracted hospitals
- The condition must be included in the CMS covered services (Section III, Page 1) and must be medically necessary (ER visits for follow-up or prescriptions are not covered)
- The place of service listed on the claim form must be the ER
Covered Emergency Room Services
- All facility, technical services and supplies provided during the emergency room episode are included in the hospital’s reimbursement
- Emergency physician, specialty physician and ambulance services are claimed and paid separately and must have occurred during the approved ER episode
- DME that is given to the patient during or after the ER episode is paid separately only when authorized by CMS

Emergency Room Follow-Up
All patients must receive information about how to obtain follow-up care through the CMS Program when they are discharged from the ER.
- Certified patients are encouraged to contact their primary care physician for continued care and referral for specialty care, if that is needed
- Standard eligibility and prior authorization are required for additional services, including follow-up by a specialty physician
- The primary care clinics are notified of their patients’ ER visits monthly and are encouraged to contact patients for follow-up care with their primary care physician

Inpatient Follow-up
One (1) follow-up office visit by the attending physician is included in the approved hospital referral when obtained within thirty (30) days of discharge. Post-operative care associated with the procedure is deemed global and is not separately reimbursed. Any laboratory and x-ray service provided during this visit requires separate authorization.

Emergency Department Services
Emergency Department services, including specialty physician services provided in the ER, are covered when provided in any San Diego acute care hospital for CMS certified patients. The emergency condition must be a physical condition within the CMS Scope of Services.

Specialist physicians providing care in a contracting emergency department do not need separate authorization; however, the episode must meet the following conditions:
- The patient must be CMS eligible for the date of service
- The condition must be included in the CMS Scope of Services
- The place of service listed on the claim form must be the emergency department at a CMS contracting hospital

Emergency Department Follow-up Care
CMS certified patients are eligible for specialty care when visit(s) have received prior authorization by AmeriChoice.
- If the patient is not already CMS certified, the patient must call the CMS Appointment Line at (800) 587-8118 to schedule an eligibility appointment. The AmeriChoice Customer Service Representatives will screen for CMS eligibility at that time.
Section 8 Medical Management

CMS Registered Nurses hold valid California nursing licenses. The nurses receive face sheets from contracting and non-contracting hospitals and censuses from contracting hospitals identifying patients who are CMS-certified or who are pending certification. The nurse case managers review these documents for high-risk indicators, and they also review medical records of CMS patients to determine if:

- The admission is appropriate
- The length of stay is appropriate
- Continued inpatient care is medically warranted
- The patient requires placement upon discharge
- The discharge planner, social worker, or case manager has started the placement process, if appropriate
- A referral to Medi-Cal for a disability evaluation is appropriate

Discharge Planning for Placement

When the hospital discharge planner identifies a patient, who needs placement in an Independent Living Facility (ILF), formerly known as a room and board facility, the discharge planner must notify the ASO Case Management Department at (858) 658-8713. To be considered for placement the patient must be CMS certified, must have obtained approval by the ASO Case Manager, and meet placement criteria.

Discharge Planning for High-Risk Patients

The discharge planner should call the ASO Case Management staff at (858) 658-8650 when a CMS certified patient is an inpatient with one or more of the following high-risk indicators:

- Tuberculosis (TB)
- Transportation issues, based upon medical need
- Homelessness (concomitant medical diagnosis is required)
- Drug and/or alcohol abuse
- Limited mental functioning
- Illiteracy
- Multiple physicians
- Complex or chronic medical conditions

The discharge planner must give the following information to the ASO Case Manager:

- Patient name
- Social Security Number
- Date of birth
- Date of admission
- Projected date of discharge
• Diagnosis (Admitting, Working, and/or Discharge)
• Discharge plan request
• Patient’s location
• Medical records (upon request)

The ASO Social Worker Case Manager may:
• Make a hospital visit
• Complete an intake form
• Review the patient’s chart
• Assess the patient for the appropriate level of care
• Identify the most appropriate Independent Living Facility and arrange placement if placement criteria are met
• Notify the discharge planner of the location of the facility (Note: hospitals are responsible for providing transportation upon discharge)

**Medication upon Discharge**

The hospital is responsible for providing no less than a full course of antibiotics and/or 3-day supply of medication at time of discharge to avoid unnecessary complications after hospitalization.

**Services and Equipment after Discharge**

The hospital discharge planner must submit all post-discharge requests for ongoing services and equipment needed to the ASO Case Manager for authorization. The ASO Case Manager will evaluate the patient for:
• Acute inpatient rehabilitation
• Outpatient rehabilitation
• Home health
• Home infusion
• Durable medical equipment

The ASO Case Manager may ask the discharge planner for additional information such as, history and physical; operative reports; lab results; MRI results; physical therapy/occupational therapy/speech therapy notes; discharge summary and/or instructions that support the need for post hospitalization services and equipment.

**In Home Care**

For patients discharged home, the ASO Case Manager may authorize certain services and medical supplies, including the following:
• Nursing assessments
Wound care
Home infusion therapies
Home rehabilitation therapies
Durable medical equipment (DME)

Treatment Plans
ASO Case Managers coordinate treatment plans by authorizing inpatient and outpatient rehabilitation, assisting with scheduling services, and making referrals to other community-based services.

Transportation
ASO Case Managers can help CMS certified patients who satisfy CMS transportation assistance criteria get transportation to medical appointments.

Public Assistance
ASO Case Managers can help CMS certified patients apply for other benefits such as General Relief (GR), Medi-Cal Disability, and Supplemental Security Insurance (SSI).

Contracting Facilities
A listing of primary care clinics, contracting hospitals and pharmacies can be found in Attachment A.
Section 9 Ancillary Services

Ancillary Health Services and Supplies
Generally, ancillary health services and supplies are covered when appropriate for the health condition. An example of a coverage limitation for a specific service includes a home health service request for suture removal for a home-bound patient.

Ancillary Services and Specific Requirements

Emergency Transportation
CMS will pay for emergency transportation to a contracting hospital for a CMS eligible patient.

Transfer Transportation
CMS will pay ambulance transportation for a level of care transfer when the sending hospital obtains an authorization number prior to the transfer and the condition is covered by CMS. The sending hospital is responsible for the transportation cost if the ASO was not notified or did not authorize the transfer.

Non-Emergency Transportation
Ambulance, taxi, and shuttle transportation services are only authorized under special circumstances. Authorization from the ASO's social services department is required for each trip.

Home Health
Includes nursing, physical, speech and occupational therapy provided in the home. Patients must be home bound during the approval period.

Initial – A copy of the physician’s prescription (including legible physician’s name), the anticipated period the service is needed, the number of encounters for each discipline. Additionally, a completed Certificate of Need is required when the patient is pending a Medi-Cal disability determination.

Extension – Progress notes must include documented progress and medical justification for continued need.

Supplies – Contact the ASO for instructions. Authorization for supplies is given directly to the preferred vendor.

Home Infusion
Initial – The requesting specialist or hospital discharge department is required to provide the diagnosis, a copy of the history and physical exam and documentation that the patient does not have a recent history of IV drug abuse. The Home Infusion vendor must provide a copy of the physician’s prescription (including legible physician’s name),
the frequency and anticipated length of time the service is needed and, when the patient is pending Medi-Cal, a completed Certificate of Need.

**Extension** – Provide the ASO with a new prescription and Certificate of Need prior to extending the treatments.

**Durable Medical Equipment and Soft Goods**

The ASO will indicate if the requested equipment will be rented or purchased. Approval for rental of durable medical equipment is time specific. The vendor is responsible for providing the ASO with medical justification for an extension of the rental period in a timely manner.

**Initial** – Provide a copy of the prescription(s), state the diagnosis and anticipated length of need; indicate rental or purchase; and provide the applicable HCPCS code(s).

**Extension** – Request the extension of a rental period from the ASO prior to the expiration date as noted on the approval notice. Provide an updated prescription, medical justification and indicate the additional length of time the equipment is needed. When rental equipment is subsequently purchased, the rental fee already paid will be deducted from the purchase price.

The ASO will always designate the vendor for the purchase of all soft goods, wound supplies, and ostomy supplies.

**Rehabilitation Therapy (outpatient physical, speech or occupational therapy)**

**Initial** – Specialists must obtain authorization from the ASO for all rehabilitation services (evaluation or for a continued course of treatment).

**Extension** – Provide a copy of the prescription, evaluation report, progress notes, if applicable, and state the anticipated number of weeks needed to reach goals. CMS encourages patient participation in a home exercise program.

**Hearing Aids**

Primary care providers can authorize a hearing evaluation. Hearing devices must be prior authorized by the ASO, and the audiologist report must accompany the request. One (1) aid will be covered when all CMS criteria are met.
Section 10 Pharmacy Services

Pharmacy Services

The CMS Program covers prescribed medications for all products listed on the CMS formulary. (All prescriptions funded by CMS must be approved by the FDA). Formulary exceptions are processed by the CMS pharmacy benefit management company. This formulary is modified on a periodic basis, and updates are provided on the CMS Website. Directions for obtaining non-formulary prescriptions are detailed in the instruction section of the CMS formulary.

Pharmacies may dispense the full-prescribed quantity of medications for certified CMS patients up to a maximum of a ninety (90) calendar day supply for specified medications per the CMS formulary. The physician determines the appropriate number of refills when prescribing maintenance drugs, however the prescriptions can be written for the full period permitted by law.
Section 11 Referrals

The County Medical Services Program maintains a network of Community Health Clinics that serve as “medical homes” to CMS patients, which provide integrated, basic primary care services. In the event the CMS patient requires specialty medical treatment, the primary care physician will complete a CMS Request for Referral Services (CMS-19 CMS Program Request For Referral Services Form – Treatment Authorization Request [TAR]) form and submit it to the AmeriChoice Medical Management Department for processing. This form is available on the CMS website. In addition, the eTAR system is available for contracted providers to submit their request for treatment authorization electronically.

Evaluations

Prior authorization is required for an evaluation and/or treatment by a specialty physician:
- Clinic completes the CMS Request for Referral Services (CMS-19 CMS Program Request For Referral Services Form – Treatment Authorization Request [TAR]) form identifying the patient, the patient’s dates of eligibility, the reason for the evaluation, the services to be authorized, and the name of the primary care practitioner
- A brief history and any pertinent test results should accompany the CMS Request for Referral Services (CMS-19 CMS Program Request For Referral Services Form – Treatment Authorization Request [TAR]) form
- The approved form will indicate an evaluation and any additional tests or procedures that are authorized
- After evaluating the patient, the specialist will send a consultation report to the referring primary care practitioner

If a CMS patient presents to a specialist physician’s office without an authorization, they should be referred to their primary care clinic. If the CMS patient has received services for an inpatient stay or an emergency room visit and requires specialty care, please call a CMS Authorization Coordinator for further assistance at (858) 658-8650.

Treatment Authorization Request (TAR)

When it is appropriate for the specialist physician to continue to follow the patient, the physician must submit a written plan of treatment (CMS-19, CMS Program Request For Referral Services Form – Treatment Authorization Request [TAR]) form directly to the CMS Medical Management mailing address or FAX number below:

County Medical Services (CMS) Program
Patient Care Authorization
PO Box 927110
San Diego, CA 92192
FAX: (855) 394-7927
All non-clinic, non-emergency services provided to CMS patients must be prior approved. Authorization from AmeriChoice is required for:

- All specialty care
- CT scans and MRIs
- Outpatient hospital services such as nuclear studies, hyperbaric treatments, invasive procedures, and outpatient surgery
- Scheduled admissions
- Special medical devices and supplies, orthotics and prosthetics, rehabilitation therapy and home health care
- Non-formulary drugs (prior authorization by the Pharmacy Benefits Manager, NMHC)

The CMS Treatment Authorization Request (TAR) form may be used when mailing or faxing the request. The request should include:

- Patient name, date of birth, Social Security number and CMS eligibility period
- Specific services requested, including treatment plan and planned procedures
- Medical findings which indicate the severity of the condition (i.e., copy of SOAP notes including signs and symptoms, history, and physical examination pertinent to the treatment requested, and, when indicated, diagnostic lab and radiology reports)
- Location where the service will be provided (office, ancillary provider, or name of facility)
- Anticipated length of stay for scheduled admissions
- Current CPT procedure codes

The authorization generally includes minor office procedures, **routine** laboratory, and radiology studies. AmeriChoice will send an approval notice to both the requesting physician and the ancillary vendor when the request has indicated that an allied service (rehab therapies, DMS, outpatient hospital procedure, etc.) is part of the patient’s plan of care.

All CMS authorizations are valid for a limited time. To ensure payment, the patient must be seen before the “valid to” date noted on the referral.

Providers must submit their request on a CMS–19, CMS Program Request for Referral Services Form (Treatment Authorization Request [TAR]), to AmeriChoice with sufficient information to support the requested medical service. Information required includes:

- History & assessment of the stated condition
- Applicable diagnostic test results
- Clinical notes specific to the condition, when appropriate

All TARs must be ordered by a physician or co-signed by a physician for physical health services. TARs ordered by a midlevel provider without a physician signature will be denied.

Turnaround time for routine TARs is ten (10) calendar days. Complete, accurate and legible information will ensure a prompt response from AmeriChoice.
Urgent TAR

AmeriChoice will process a TAR as urgent only when services are needed because of a patient's immediate medical condition. In addition to the usual patient identification, indicate the medical service needed and document sufficient information to establish the medical urgency. Legibility and appropriate documentation are important.

If the patient’s condition is life threatening, refer the patient to the nearest CMS contracting hospital or call 911. Emergency care does not require prior approval; medically necessary ambulance service is covered for eligible patients when taken to a contracted hospital.

Notifications – Approval

After the service is reviewed, the physician’s office will receive notification of the outcome, usually within (7) business days. The CMS Treatment Authorization Notification form states the authorization number, the service(s) authorized, and the effective dates of the authorization based on either the plan of care or the patient’s eligibility dates. When the service cannot be provided before the expiration date, contact AmeriChoice Provider Line to request an extension of the period before providing the care.

- Repeated requests for retro authorization due to administrative oversight may result in denials. All claims submitted for services provided beyond the “valid to” date are rejected as outside of the approved period.

Notifications – Denial

Only the CMS Program Medical Director can deny a service as medically unnecessary. Other types of TAR denials include administrative, criteria not met, and non-covered benefit.

Reconsideration and Appeal Process

The ordering physician may ask the Medical Director to reconsider the denial for a medical service. The patient is also notified that a service has been denied and is informed of their rights and the appeal process. Either party’s request for reconsideration must be submitted in writing within thirty (30) days of the date of denial. Send the request to the following address:

CMS Program
Attn: Medical Appeals
PO Box 927110
San Diego, CA 92192
Phone: (858) 658-8650
Fax: (855) 394-7927

The ASO Medical Management will review the case in depth and may contact the physician or other providers for additional information. The physician and the patient will be notified of the decision within forty-five (45) calendar days from receipt of the request for reconsideration or appeal. Expedited requests for reconsideration must be submitted within three (3) business days of the date of the denial.
The following diagnostic studies, radiographs and DMEs **do not** require authorization:

<table>
<thead>
<tr>
<th>Diagnostic Studies</th>
<th>Radiographs</th>
<th>DME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiogram</td>
<td>Barium enema</td>
<td>Crutches</td>
</tr>
<tr>
<td>Cardiovascular stress test</td>
<td>Barium swallow</td>
<td>Elastic support brace</td>
</tr>
<tr>
<td>(Treadmill)</td>
<td>Colposcopy Procedure</td>
<td>Standard one-point cane</td>
</tr>
<tr>
<td>Diagnostic mammogram</td>
<td>IVP</td>
<td></td>
</tr>
<tr>
<td>Doppler</td>
<td>Diagnostic mammogram</td>
<td></td>
</tr>
<tr>
<td>Echocardiogram</td>
<td>Sonogram</td>
<td></td>
</tr>
<tr>
<td>EEG</td>
<td>Ultrasound</td>
<td></td>
</tr>
<tr>
<td>PFT</td>
<td>Upper GI</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Sigmoidoscopy</td>
<td>X-rays</td>
<td></td>
</tr>
<tr>
<td>Holter monitor</td>
<td>4+ views</td>
<td></td>
</tr>
</tbody>
</table>
Referral Services

AmeriChoice Medical Management reviews Treatment Authorization Requests (TAR) from clinics and specialists. Planned admissions, surgical procedures, ancillary/supportive services, specialty care, and the following services require authorization from AmeriChoice’s Medical Management:

<table>
<thead>
<tr>
<th>Diagnostic Studies</th>
<th>Consults</th>
<th>DME</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CT Scan</td>
<td>• Cardiology</td>
<td>• All DME that meet LIHP Medical Policy criteria and received TAR approval</td>
</tr>
<tr>
<td>• MRI</td>
<td>• Dermatology</td>
<td></td>
</tr>
<tr>
<td>• Non-formulary products</td>
<td>• Endocrinology</td>
<td></td>
</tr>
<tr>
<td>• Nuclear studies</td>
<td>• ENT</td>
<td></td>
</tr>
<tr>
<td>• P.E.T. Scan</td>
<td>• Gastroenterology</td>
<td></td>
</tr>
<tr>
<td>• Simple biopsy by a Dermatologist</td>
<td>• Gynecology</td>
<td></td>
</tr>
<tr>
<td>• Sleep Studies (Attach sleep study form)</td>
<td>• Hernia repair evaluation (with work history form completed)</td>
<td></td>
</tr>
<tr>
<td>• EMG, Limited</td>
<td>• Nephrology</td>
<td></td>
</tr>
<tr>
<td>• Nerve conduction study</td>
<td>• Neurology</td>
<td></td>
</tr>
<tr>
<td>• Radiology Guided Biopsy</td>
<td>• Neurosurgery</td>
<td></td>
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<tr>
<td></td>
<td>• Oncology</td>
<td></td>
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<tr>
<td></td>
<td>• Ophthalmology</td>
<td></td>
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<tr>
<td></td>
<td>• Optometry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Orthopedics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pain Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical Therapy (evaluation only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Podiatry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulmonology</td>
<td></td>
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<tr>
<td></td>
<td>• Rheumatology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Surgery</td>
<td></td>
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<tr>
<td></td>
<td>• Urology</td>
<td></td>
</tr>
</tbody>
</table>

Please refer to Section 12 of this handbook for information concerning a beneficiary’s rights and processes of Grievance and Appeals.
Section 12 Grievances and Appeals

The CMS Complaint and Medical Appeal process provides a method for CMS Program Administration and AmeriChoice to investigate and resolve complaints and appeals filed by patients and providers.

Complaints

A complaint is a written or verbal expression of dissatisfaction with access to care, quality of services, denial of services, etc. Primary care clinics must have an internal complaint process to handle complaints and to monitor quality of services. The clinic must use its internal process to try to resolve patient complaints about clinic services and treatment plans. Clinics may ask AmeriChoice for clarification of program coverage and procedures by forwarding pertinent information to AmeriChoice; they will work with clinics and patients to facilitate communication and provide information.

When efforts to resolve the complaints are unsuccessful and the differences between a patient and a provider are irreconcilable, Clinic Administration may ask the patient to transfer to another clinic. Clinic Administration must:
1. Send a written notice to the patient stating that after thirty (30) days the clinic will no longer treat them.
2. Tell the patient to call the CMS Patient Information Line to change primary care provider.
3. Send a copy of the letter with a summary of the patient’s medical services to AmeriChoice, Attention: Case Management Program.

Medical Appeals

The CMS Program utilizes a two-tiered appeal process of reconsideration and appeal. Instructions for requesting a review are referenced on the Request for Authorization Denial Notice Form. Patients are encouraged to discuss the denial and other treatment options with their physician before filing an appeal with the AmeriChoice Patient Relations Department.

Both the patient and the requesting provider will receive written notification of a medical service denial, and either one may contact AmeriChoice and request clarification or may appeal the denial within thirty (30) days of receiving the denial notice.

All written and verbal inquiries to AmeriChoice, whether from the patient or the provider, will initiate an investigation. The Medical Appeal Process has two levels. The first level is called a Reconsideration and the second level is called an Appeal. When AmeriChoice denies a Request for Authorization, a written denial notice is sent to the patient, and a copy to the Primary Care Provider who requested authorization. Patients should review the denial with the Primary Care Provider and discuss other treatment options. Either the patient or the provider may contact AmeriChoice to obtain clarification or to file a Reconsideration.
Reconsideration

The patient or provider must submit a written request for reconsideration to AmeriChoice within 30 calendar days from the date of the service denial notice. Upon receipt of the request for reconsideration AmeriChoice will:

1. Contact the patient to clarify the details of the denial.
2. Review the denial and contact the requesting primary care provider or specialty physician to obtain additional medical information or clarification and re-evaluate the request.
3. Seek an opinion from an independent specialty physician, as needed.
4. Send a written decision to the patient, the requesting physician, and the patient’s primary care provider within forty-five days after receipt of the reconsideration request.

Appeal

The patient, the patient’s authorized representative or provider must submit a written request to the CMS Program Administration within 30 calendar days from the date of the reconsideration decision notice. Upon receipt of the request for an Appeal, AmeriChoice and CMS Program Administration will:

1. Assemble an independent panel and schedule a hearing.
2. Summarize the independent panel’s findings and recommendations.
3. Prepare the Final Decision Notice for the Health and Human Services Agency Director’s signature.
Section 13 Claims

AmeriChoice processes all claims submitted by hospitals, clinics, specialty physicians and ancillary providers seeking payment from the CMS Program.

Submission Requirements

All claims must:

• Be for services and service dates that match the certified patient’s eligibility and period authorized.

• Be submitted electronically or on the CMS–1500 Form (Note: When the patient has other health coverage (OHC), you must submit a claim to the other insurance carrier first, and then attach the other carrier’s EOB to the CMS 1500 before submitting your claim to CMS).

• Include the following information:
  − Patient name, birth date, Social Security Number, or CMS Member ID
  − Date(s) of service
  − Place of service
  − Vendor and group name, address, and phone number
  − Name and address of facility where services were rendered (if different from the billing office)
  − Medi-Cal Provider number
  − Provider Tax ID number
  − Individual and organizational NPI
  − ICD–9 Codes
  − Current RVS, CPT, HCPCS, DRG and Medi–Cal codes as indicated
  − Authorization number (TAR control number)
  − Referring physician required
  − Full itemization of charges, including drugs and supplies provided
  − All documentation and attachments required by Medi–Cal
  − Catalogue page or invoice when submitting an unlisted or “miscellaneous” code
  − Be submitted within thirty (30) days from the date of services but no later than July 31 to:

    AmeriChoice
    County Medical Services (CMS) Program
    Claims Office
    PO Box 927110
    San Diego, CA 92192

Checking Claim Status

AmeriChoice processes claims that are complete and accurate within 30 days of receipt. If you have not received payment within 45 days, please email inquiries to COSD_claims@uhc.com or fax inquiries to (855) 394–7927. All claims related inquiries, including questions regarding
claim status must be emailed or faxed.

**Share of Cost**

Effective July 1, 2008, CMS Providers are to continue the current billing practice for CMS reimbursement, and the provider will receive full CMS reimbursement for all approved claims regardless of whether their CMS patient has a SOC. The SOC collection shall be seamless to the provider. When the County receives a CMS provider claim for CMS covered services provided to a SOC patient, the County will bill the patient for their monthly SOC or the amount of CMS services, whichever is less. Individuals will not be billed for any months in which they did not receive CMS services.

**Reimbursement**

Checks and the Remittance Advice (RA) are produced twice a month. CMS reimbursement is considered payment in full.

- Specify the CPT codes for **all** services provided by the clinic during the visit.
  - All covered supplemental services provided in the clinic will be paid at Medi-Cal or negotiated rates.
- All CMS dental services (basic and pre-approved) are paid at Denti-Cal rates.
- All pre-approved optometry services are paid at Medi-Cal rates.

The actual utilization and level of the Primary Care Pool fund will be assessed quarterly. If necessary, interim payment rates may be adjusted to ensure, to the greatest extent possible, that the pool will not be depleted prior to the end of the contract year.

You may not bill patients for:

- Any balance of fees or other associated costs after CMS pays for the service(s)
- Any hospital administrative errors (incorrect coding, failure to obtain timely authorization or late submission)

You may bill patients for:

- Unauthorized services
- Services not covered in the CMS Program Scope of Services

**Payment Rates**

Claims are paid based on Medi-Cal Fee Schedule and Guidelines. See Section 14 – Provider Reimbursement Schedule for more information.

**Notification of Changes to Provider Information**

To ensure your check and RA is accurate and timely, immediately notify AmeriChoice’s Claims Department via email (COSD_claims@uhc.com) or fax (855–394–7927):

- Ownership
- Address (mailing and/or service site)
- Group affiliation
Clinics must provide the AmeriChoice Claims Department with a listing of licensed providers employed by the clinic (MD, DO, RNP and PA). Copies of license numbers and if applicable, DEA numbers are required. Staff additions and any corrections should be forwarded to AmeriChoice as they occur to avoid unnecessary delays or denial of claims.

**Medi-Cal Pending**

CMS covers necessary medical care for certified patients while their Medi-Cal disability evaluation is pending. AmeriChoice will process claims for these patients following standard CMS procedures.

**Medi-Cal Approved**

AmeriChoice will notify providers of the Medi-Cal approval on the RA. AmeriChoice will deny all claims received after the patient has been approved for Medi-Cal. For claims AmeriChoice has paid:

- Providers must bill Medi-Cal directly once Medi-Cal eligibility is approved
- In the event you receive payment from Medi-Cal for a service previously paid by AmeriChoice, you must reimburse the CMS Program

**Appeal Process for Denied Claims**

If a claim submitted to the CMS Program for payment is denied, you may ask for an appeal and must resubmit the claim within 30 days of the denial notification. The reason for the appeal and additional justification for payment must be clearly stated. Send all claims for appeals to the following address:

**CMS Program – Appeals**

**Attention: Claims Department**

**PO Box 927110**

**San Diego, California 92192**

If you have questions, email (COSD_claims@uhc.com) or fax (855–394–7927) the Claims Department for instructions on how to submit your appeal. AmeriChoice will review the claim and additional information and notify you of the decision within 45 calendar days.

**End of Year Close–Out**

The CMS Program fiscal year ends on June 30 of each year. All claims for services provided to patients certified or referred to CMS in a fiscal year must be submitted to AmeriChoice by July 31, regardless of authorization or eligibility status.
## Section 14 Provider Reimbursement Schedule

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Reimbursement Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>Medi-Cal APR-DRG</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>100% Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>Specialist</td>
<td>150% of Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>Specialist – Ortho/Neuro Surgery</td>
<td>150% of Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>Ancillary Provider &amp; Services</td>
<td>100% Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>Primary Care Services Provider</td>
<td>E&amp;M codes paid at 280% of current Medi-Cal Fee Schedule; all other services paid at 100% of the current Denti-Cal Fee Schedule</td>
</tr>
<tr>
<td>UCSD Medical Group</td>
<td>150% Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>UCSD Med Group Ortho and Neuro Surgery</td>
<td>150% Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td>100% Medi-Cal Fee Schedule</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% Medi-Cal Fee Schedule</td>
</tr>
</tbody>
</table>
Section 15 Definitions

Administrative Services Organization
The private organization retained by the County to provide administrative support to CMS.

County
County of San Diego, a political subdivision of the State of California.

Beneficiary
An individual who has been approved for the CMS benefits.

Emergency Medical Condition
Per Special Terms & Conditions (63): a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Individual
An applicant for the CMS whose eligibility has not yet been determined.

Network Provider
A provider who has a contract with the County of San Diego to provide CMS services.

Out-of-Network Provider
A provider who does not have a contract with the County of San Diego to provide CMS services.
Section 16 CMS Dental Locations (Appointments Are Required)

Comprehensive Health Center
3177 Oceanview Boulevard San Diego, CA 92113
(619) 231–9300

Fallbrook Family Health Center
1328 South Mission Road Fallbrook, CA 92028
(760) 451–4720

Family Health Centers San Diego – City Heights Dental Clinic
5454 El Cajon Boulevard San Diego, CA 92115
(619) 515–2442

Family Health Centers San Diego – Diamond Neighborhoods Clinic
4725 Market Street San Diego, CA 92102
(619) 515–2560

Family Health Centers San Diego – Elm Street Dental Clinic
140 Elm Street San Diego, CA 92101
(619) 515–2543

Family Health Centers San Diego – Grossmont/Spring Valley Dental
8788 Jamacha Road Spring Valley, CA 91977
(619) 515–2330

Family Health Centers San Diego – Logan Heights Dental Clinic
1809 National Avenue San Diego, CA 92113
(619) 515–2394

Family Health Centers San Diego – North Park/Hillcrest Dental Clinic
3544 30th Street San Diego, CA 92104
(619) 515–2434

Family Health Centers San Diego – Ibarra Family Health Center
4874 Polk Avenue San Diego, CA 92105
(619) 515–2426

La Maestra Family Clinic – El Cajon
183 South First Street El Cajon, CA 92019
(619) 328–1335

La Maestra Family Clinic
4305 University, Suite 120 San Diego, CA 92105 (619) 285–8135

Neighborhood Healthcare – Lakeside Dental
10039 Vine Street Lakeside, CA 92040
(619) 390–9975

Neighborhood Healthcare – Pauma Valley
16650 Hwy. 76 Pauma Valley, CA 92061
(760) 742–9919

Neighborhood Healthcare – Ray M. Dickinson Wellness Center
425 North Date, Suite 125 Escondido, CA 92025
(760) 737–2018

Operation Samahan – Camino Ruiz
10737 Camino Ruiz, Suite 235 San Diego, CA 92126
(858) 578–4220

Operation Samahan—Highland
2743 Highland Avenue National City, CA 91950
(619) 474–2284

San Ysidro Health Center
4004 Beyer Blvd San Ysidro, CA 92173
(619) 662–4180

Vista Community Clinic
1000 Vale Terrace Vista, CA 92084
(760) 631–5000
Section 17 CMS Hospitals

Alvarado Hospital
6655 Alvarado Road
San Diego, CA 92120
(619) 287–3270

Palomar Health Downtown Campus
555 East Valley Parkway Escondido, CA 92025
(760) 739–3000

Palomar Medical Center
2185 Citracado Parkway
Escondido, CA 92029
(442) 281–5000

Paradise Valley Hospital
2400 East Fourth Street
National City, CA 91950
(619) 470–4321

Pomerado Hospital
15615 Pomerado Road
Poway, CA 92064–2405
(858) 613–4000

Promise Hospital of San Diego
5550 University Avenue
San Diego, CA 92105
(619) 582–3516

Scripps Memorial – Encinitas
354 Santa Fe Drive Encinitas, CA 92024
(760) 753–6501

Scripps Memorial – La Jolla
9888 Genesee Avenue
La Jolla, CA 92037
(858) 457–4123

Scripps Mercy Hospital
4077 Fifth Avenue
San Diego, CA 92103
(619) 294–8111

Scripps Mercy Hospital – Chula Vista
435 H Street
Chula Vista, CA 91910
(619) 691–7000

Sharp Chula Vista Medical Center
751 Medical Center Court
Chula Vista, CA 91911
(619) 502–5800

Sharp Coronado Hospital
250 Prospect Place
Coronado, CA 92118
(619) 522–3600

Sharp– Grossmont Hospital
5555 Grossmont Center Drive
La Mesa, CA 91942
(619) 740–6000

Sharp Memorial Hospital
7901 Frost Street
San Diego, CA 92123
(858) 939–3400

Tri–City Medical Center
4002 Vista Way
Oceanside, CA 92056
(760) 724–8411

UCSD Medical Center
200 West Arbor Drive
San Diego, CA 92103
(619) 543–6222

UCSD Thornton Hospital
9300 Campus Point Drive
La Jolla, CA 92037
(858) 550–0115
Section 18 CMS Primary Care Clinics

BORREGO SPRINGS MEDICAL CENTER
4343 Yaqui Pass Road
Borrego Springs, CA 92004
(760) 767-5051

Centro Medico – El Cajon
133 West Main Street
El Cajon, CA 92020
(619) 401-0404

Borrego Julian Medical Clinic
2721 Washington Street
Julian, CA 92036
(760) 765-1223

COMMUNITY HEALTH SYSTEMS
Fallbrook Family Health Center
1328 South Mission Road
Fallbrook, CA 92028
(760) 451-4720

FAMILY HEALTH CENTERS (FHC) OF SAN DIEGO
(continued)
Connections FHC
1250 6th Avenue, Suite 100
San Diego, CA 92101
619-515-2430

Diamond Neighborhoods FHC
4725 Market Street
San Diego, CA 92102
(619) 515-2560

Elm Street FHC
140 Elm Street
San Diego, CA 92101
(619) 515-2520

Grossmont/Spring Valley FHC
8788 Jamacha Road
Spring Valley, CA 91977
(619) 515-2555

Lemon Grove FHC
7592 Broadway
Lemon Grove, CA 91945
(619) 515-2550

Logan Heights FHC
1809 National Avenue
San Diego, CA 92113
(619) 515-2300

North Park FHC
3544 30th Street
San Diego, CA 92104
(619) 515-2424

Sherman Heights FHC
2391 Island Avenue
San Diego, CA 92102
(619) 515-2435

Chula Vista FHC
251 Landis Avenue
Chula Vista, CA 91910
(619) 515-2500

City Heights FHC
5454 El Cajon Boulevard
San Diego, CA 92115
(619) 515-2400

FAMILY HEALTH CENTERS (FHC) OF SAN DIEGO
(FHCS) of San Diego
Beach Area FHC
3705 Mission Boulevard
San Diego, CA 92109
(619) 515-2444

Chase Avenue FHC
111 West Chase Avenue
El Cajon, CA 92020 (619) 515–2499

Chula Vista FHC
251 Landis Avenue
Chula Vista, CA 91910
(619) 515–2500

City Heights FHC
5454 El Cajon Boulevard
San Diego, CA 92115
(619) 515–2400

FAMILY HEALTH CENTERS (FHC) OF SAN DIEGO
(continued)
Connections FHC
1250 6th Avenue, Suite 100
San Diego, CA 92101
619–515–2430

Diamond Neighborhoods FHC
4725 Market Street
San Diego, CA 92102
(619) 515–2560

Elm Street FHC
140 Elm Street
San Diego, CA 92101
(619) 515–2520

Grossmont/Spring Valley FHC
8788 Jamacha Road
Spring Valley, CA 91977
(619) 515–2555

Lemon Grove FHC
7592 Broadway
Lemon Grove, CA 91945
(619) 515–2550

Logan Heights FHC
1809 National Avenue
San Diego, CA 92113
(619) 515–2300

North Park FHC
3544 30th Street
San Diego, CA 92104
(619) 515–2424

Sherman Heights FHC
2391 Island Avenue
San Diego, CA 92102
(619) 515–2435
IMPERIAL BEACH HEALTH CENTER
949 Palm Avenue
Imperial Beach, CA 91932
(619) 429–3733

Nestor
1016 Outer Road
San Diego, CA 92154 (619) 429–3733

LA MAESTRA FAMILY CLINIC
San Diego
4060 Fairmount Avenue
San Diego, CA 92105
(619) 280–4213

El Cajon
165 South First Street
El Cajon, CA 92019
(619) 779–7900

National City
217 Highland Avenue
National City, CA 91950
(619) 434–7308

MOUNTAIN HEALTH & COMMUNITY SERVICES (continued)
Alpine Family Medicine
1620 Alpine Boulevard #B119
Alpine, CA 91901
(619) 445–6200

Escondido Family Medicine
255 North Ash Street, Suite 101
Escondido, CA 92027
(760) 745–5832

Mountain Empire Family Medicine
31115 Highway 94
Campo, CA 91906
(619) 478–5311

NEIGHBORHOOD HEALTHCARE
El Cajon
855 East Madison
El Cajon, CA 92020
(619) 440–2751

Lakeside
10039 Vine Street
Lakeside, CA 92040
(619) 390–9975

Escondido – North Elm
460 North Elm Street
Escondido, CA 92025
(760) 737–2000

Escondido – Grand
1001 E. Grand Avenue
Escondido, CA 92025
(760) 520–8200

Pauma Valley
16650 Highway 76
Pauma Valley, CA 92061
(760) 742–9919

Ray M. Dickinson Wellness Center
425 North Date Street, Suite 203
Escondido, CA 92025
(760) 520–8300

NORTH COUNTY HEALTH SERVICES
Ramona Health Center
220 Rotanzi Street
Ramona, CA 92065
(760) 736–6767
OPERATION SAMAHAN INC.
Health Clinic
10737 Camino Ruiz, Suite 235
San Diego, CA 92126
(858) 578-4220

Family Clinic
2743 Highland Avenue
National City, CA 91950
(619) 474-8686

Community Health Center
2835 Highland Ave., Suite A
National City, CA 91950
(619) 474-5567

SAN DIEGO AMERICAN INDIAN HEALTH CENTER
2630 First Avenue San Diego, CA 92103
(619) 234-2158

SAN DIEGO FAMILY CARE
Linda Vista Health Care Center
6973 Linda Vista Road
San Diego, CA 92111
(858) 279-0925

Mid-City Community Clinic
4290 Polk Avenue
San Diego, CA 92105
(619) 563-0250

SAN YSIDRO HEALTH CENTER
4004 Beyer Boulevard
San Ysidro, CA 92173
(619) 428-4463

Chula Vista Medical Plaza
678 Third Avenue
Chula Vista, CA 91910
(619) 662-4100

SAN YSIDRO HEALTH CENTER (continued)
Comprehensive Health Center – Ocean View
3177 Ocean View Boulevard
San Diego, CA 92113
(619) 231-9300

King–Chavez Health Center—Euclid
950 Euclid Avenue
San Diego, CA 92114
(619) 662-4100

National City Family Clinic
1136 D Avenue
National City, CA 91950
(619) 336-2300

Otay Family Health Center
1637 Third Avenue, Suite B
Chula Vista, CA 91911 (619) 205-1360

Paradise Hills Family Clinic
2400 E. 8th Street, Suite A
National City, CA 91950
(619) 662-4100

SOUTHERN INDIAN HEALTH COUNCIL
Alpine Clinic
4058 Willows Road
Alpine, CA 91901
(619) 445-1188

Campo Clinic 36350
Church Road
Campo, CA 91906-0498
(619) 445-1188 x700

ST. VINCENT de PAUL VILLAGE FAMILY CENTER
1501 Imperial Avenue
San Diego, CA 92101
(619) 233-8500
VISTA COMMUNITY CLINICS
Vista Community Clinic
1000 Vale Terrace
Vista, CA 92084
(760) 631–5000

Vista Community Clinic – Grapevine
134 Grapevine Drive
Vista, CA 92083
(760) 631–5000

Vista Community Clinic – Horne Street
517 N. Horne Street
Oceanside, CA 92054
(760) 631–5000

Vista Community Clinic – North River Rd
4700 North River Road
Oceanside, CA 92057
(760) 631–5000

Vista Community Clinic – Pier View Way
819 Pier View Way
Oceanside, CA 92154
(760) 631–5000
## Section 19 CMS Network Pharmacy Locations

Patients need to check with specific pharmacies for delivery details.

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Address</th>
<th>City, State</th>
<th>Zip Code</th>
<th>Phone Number</th>
<th>Delivery Details</th>
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<tbody>
<tr>
<td>AD–RX Pharmacy</td>
<td>6240 Wilshire Boulevard</td>
<td>Los Angeles, CA</td>
<td>90048</td>
<td>(323) 936–8221</td>
<td>Free Delivery in CA.</td>
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<tr>
<td>Allen’s Pharmacy</td>
<td>1141 6th Ave.</td>
<td>San Diego, CA</td>
<td>92101</td>
<td>(619) 232–8101</td>
<td>Free Mail/Delivery</td>
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<td>Asmar Community Pharmacy</td>
<td>436 S. Magnolia St.</td>
<td>El Cajon, CA</td>
<td>92020</td>
<td>(619) 447–9900</td>
<td>Free Delivery/No Mail</td>
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<tr>
<td>Best Pharmacy</td>
<td>5507 El Cajon Boulevard</td>
<td>San Diego, CA</td>
<td>92115</td>
<td>(619) 582–4466</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td><em>Borrego Community Health Foundation Pharmacy</em></td>
<td>655 Palm Canyon Drive, Suite B</td>
<td>Borrego Springs, CA</td>
<td>92004 (760)</td>
<td>767–3047</td>
<td>Charge for Mail/No Delivery</td>
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<tr>
<td>Community Medical Center Pharmacy</td>
<td>610 Gateway Center Way, Ste A</td>
<td>San Diego, CA</td>
<td>92102</td>
<td>(619) 262–4373</td>
<td>Free Mail/Delivery with &gt; 1 Rx</td>
</tr>
<tr>
<td>Community Medical Center Pharmacy</td>
<td>750 Medical Center Court</td>
<td>Chula Vista, CA</td>
<td>91911</td>
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County of San Diego County Medical Services (CMS) Program
Provider Handbook

Medical Center Pharmacy
7910 Frost Street Suite 103
San Diego, CA 92123
(858) 560–1911
Free Mail/Delivery

Modern Healthcare Pharmacy
13220 Evening Creek Drive, Suite 110
San Diego, CA 92128
(858) 668–3350
Free Delivery

*Neighborhood Healthcare
460 North Elm Street
Escondido, CA 92025
(760) 737–2025
No Mail/Delivery

Nudo’s Pharmacy
455 North Magnolia Avenue
El Cajon, CA 92020
(619) 442–0303
Free Mail Delivery

Premier Pharmacy #4 – Previously Edwins Pharmacy
12500 Burbank Blvd.
Valley Village, CA 91607
(888) 619–6196
Free specialty mail order service/next day delivery

AHF Pharmacy – Previously Priority Pharmacy
3940 Fourth Avenue, Suite 150
San Diego, CA 92103
(619) 574–9700
Free Mail/Delivery

Px Drugstore
5300 Lankershim Boulevard, Suite 160
North Hollywood, CA 91601
(818) 769–0313
Free Mail/Delivery

Quality Care Pharmacy
727 West San Marcos Blvd.
San Marcos, CA 92078 (760) 744–5959
Free Mail/Delivery

Rite Aid
1665 Alpine Boulevard
Alpine, CA 91901
(619) 659–1085
No Mail/Delivery

Rite Aid
7224 Broadway
Lemon Grove, CA 91945
(619) 465–6694
No Mail/Delivery

Rite Aid
427 C Street, Suite 100
San Diego, CA 92101
(619) 233–1666
No Mail/Delivery

Rite Aid
6939 Linda Vista Road
San Diego, CA 92111
(858) 277–6730
No Mail/Delivery

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<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone Number</th>
<th>Delivery Charge</th>
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<tbody>
<tr>
<td>UCSD Edith and William Perlman Pharmacy</td>
<td>9350 Campus Point Dr.</td>
<td>La Jolla, CA 92037</td>
<td>(858) 657-8610</td>
<td>Free Mail/Delivery</td>
</tr>
<tr>
<td>*Vista Community Clinic #1</td>
<td>1000 Vale Terrace Drive</td>
<td>Vista, CA 92084</td>
<td>(760) 631-5000</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>*Vista Community Clinic #2</td>
<td>134 Grapevine Road</td>
<td>Vista, CA 92083</td>
<td>(760) 631-5000</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>*Vista Community Clinic #3</td>
<td>818 Pier View Way</td>
<td>Oceanside, CA 92054</td>
<td>(760) 631-5000</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Vons</td>
<td>3645 Midway Drive</td>
<td>San Diego, CA 92110</td>
<td>(619) 222-9736</td>
<td>$7.95 Delivery Charge</td>
</tr>
<tr>
<td>Vons</td>
<td>4145 30th Street</td>
<td>San Diego, CA 92104</td>
<td>(619) 284-3582</td>
<td>Free Delivery M–F</td>
</tr>
<tr>
<td>Vons</td>
<td>933 Sweetwater Road</td>
<td>Spring Valley, CA 91977</td>
<td>(619) 460-6336</td>
<td>$7.95 Delivery Charge</td>
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<td>Walgreens</td>
<td>1430 Eastlake Parkway</td>
<td>Chula Vista, CA 91915</td>
<td>(619) 591-7042</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>621 I Street</td>
<td>Chula Vista, CA 91910</td>
<td>(619) 407-4057</td>
<td>No Mail/Delivery</td>
</tr>
</tbody>
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## County of San Diego County Medical Services (CMS) Program

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<th>Pharmacy</th>
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<th>Phone</th>
<th>Notes</th>
</tr>
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<tr>
<td>Walgreens</td>
<td>215 North Second Street, El Cajon, CA 92021</td>
<td>(619) 401-0761</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>111 West Washington Avenue, Escondido, CA</td>
<td>(760) 291-0299</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>1574 East Valley Parkway, Escondido, CA</td>
<td>(760) 839-7932</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>460 West Felicita Avenue, Escondido, CA</td>
<td>(760) 735-6025</td>
<td>No Mail/Delivery</td>
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<tr>
<td>Walgreens</td>
<td>1285 South Mission Road, Fallbrook, CA</td>
<td>(760) 451-2970</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>9728 Winter Gardens Boulevard, Lakeside, CA</td>
<td>(619) 938-0069</td>
<td>No Mail/Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>30251 Murrieta Road, Menifee, CA 92584</td>
<td>(951) 244-7210</td>
<td>Charges for Delivery</td>
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<tr>
<td>Walgreens</td>
<td>111 West Washington Avenue, Escondido, CA</td>
<td>(760) 291-0299</td>
<td>Free Standard Shipping</td>
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<tr>
<td>Walgreens</td>
<td>27714 Clinton Keith Road, Murrieta, CA</td>
<td>(951) 672-1214</td>
<td>Free Delivery in Certain Zip Codes</td>
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<tr>
<td>Walgreens</td>
<td>29910 Murrieta Hot Springs Road, Murrieta, CA</td>
<td>(951) 894-1476</td>
<td>No Mail/Delivery</td>
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<tr>
<td>Walgreens</td>
<td>33060 Antelope Road, Murrieta, CA 92584</td>
<td>(951) 301-0670</td>
<td>No Mail/Delivery</td>
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<tr>
<td>Walgreens</td>
<td>40420 Murrieta Hot Springs Road, Murrieta, CA</td>
<td>(951) 698-7459</td>
<td>No Mail/Delivery</td>
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<tr>
<td>Walgreens</td>
<td>40663 California Oaks Road, Murrieta, CA</td>
<td>(951) 304-1219</td>
<td>No Mail/Delivery</td>
</tr>
</tbody>
</table>

*Patient must be assigned to this community health center, otherwise they will need to have their prescriptions filled at one of the designated CMS pharmacies.*
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<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Delivery Options</th>
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<tbody>
<tr>
<td>Walgreens</td>
<td>3507 Cannon Road</td>
<td>Oceanside, CA 92056</td>
<td>(760) 630–1327</td>
<td>No Mail/Delivery</td>
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<tr>
<td>Walmart</td>
<td>1150 Broadway</td>
<td>Chula Vista, CA 91911</td>
<td>(619) 591–4909</td>
<td>1–800–273–3455 for Delivery</td>
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<td>Walgreens</td>
<td>802 South Santa Fe Avenue</td>
<td>Vista, CA 92084</td>
<td>(760) 724–2833</td>
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<tr>
<td>Walmart</td>
<td>13487 Camino Canada</td>
<td>El Cajon, CA 92021</td>
<td>(619) 561–2420</td>
<td>1–800–273–3455 for Delivery</td>
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<td>Walgreens</td>
<td>1111 Third Avenue</td>
<td>Chula Vista, CA 91911</td>
<td>(619) 691–1308</td>
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<tr>
<td>Walmart</td>
<td>605 Fletcher Parkway</td>
<td>El Cajon, CA 92020</td>
<td>(619) 440–0848</td>
<td>1–800–273–3455 for Delivery</td>
</tr>
<tr>
<td>Walgreens</td>
<td>3752 Mission Avenue</td>
<td>Oceanside, CA 92054</td>
<td>(760) 722–9409</td>
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<tr>
<td>Walmart</td>
<td>1200 Highland Avenue</td>
<td>National City, CA 91950</td>
<td>(619) 336–1607</td>
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<tr>
<td>Walgreens</td>
<td>310 Sycamore Avenue</td>
<td>Vista, CA 92083</td>
<td>(760) 630–5723</td>
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</tr>
<tr>
<td>Walmart</td>
<td>3405 Marron Road</td>
<td>Oceanside, CA 92056</td>
<td>(760) 730–7386</td>
<td>1–800–273–3455 for Delivery</td>
</tr>
<tr>
<td>Walmart</td>
<td>75 Broadway</td>
<td>Chula Vista, CA 91910</td>
<td>(619) 691–0873</td>
<td>1–800–273–3455 for Delivery</td>
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<tr>
<td>Walmart</td>
<td>705 College Boulevard</td>
<td>Oceanside, CA 92057</td>
<td>(760) 631–1857</td>
<td>1–800–273–3455 for Delivery</td>
</tr>
</tbody>
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Walmart
3382 Murphy Canyon Road
San Diego, CA 92123 (858)
571–6971
1–800–273–3455 for Delivery

Walmart
3412 College Avenue
San Diego, CA 92115
(619) 858–0074
1–800–273–3455 for Delivery

Walmart
732 Center Drive
San Marcos, CA 92069
(760) 233–8971
1–800–273–3455 for Delivery

Walmart
2100 Vista Way
Oceanside, CA 92054
(760) 966–0143
1–800–273–3455 for Delivery

Walmart
32225 Temecula Parkway
Temecula, CA 92592
(951) 506–7631
1–800–273–3455 for Delivery