Request for Eligibility Verification

Date: ______________________________

To: Mental Health Patient Financial Services Department
Phone: 925-313-7750
Fax: 925-646-4165

From: ______________________________ ______________________________
(Name of Program Clerk) **(Name of Program Manager/Supervisor/Clinician)**

______________________________ ______________________________
(Program Fax Number) **(Program Phone Number)**

____
(Reporting Unit Number)

Name of Parent/Guardian or Client Contact ______________________________

Client Contact Daytime Phone: ______________________________ MRN: ______________________

CLIENT INFORMATION

Client Name: ______________________________ ______________________ __________
(Last) **(First)** **(MI)**

Address: ______________________________ ______________ ____ ________
(Street Address) **(City)** **(State)** **(ZIP)**

Phone: ____________________ SSN: ________________ Date of Birth: ________________

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other ______________
Comments:

To be completed by Mental Health PFSS Unit

Medi-Cal: ☐ Yes ☐ No **County Code:** ☐ 07/Contra Costa ☐ Other County Code: ________

Medi-Cal Aid Code: ____________________ (Call PFSS for clarification)

Medicare (only): ☐ Yes ☐ No
Uninsured: ☐ Yes ☐ No
ERMHS: ☐ Yes ☐ No
Private Insurance: ☐ Yes ☐ No Name of Insurance Company: ______________________________

Referred back to Insurance Company: ☐ Yes ☐ No Date notification made: ____________________
Eligible for MH Services: ☐ Yes ☐ No
Comments:

Date Eligibility Checked: ________________________ PFSS Initials: ____________________