MENTAL HEALTH SERVICES
Void & Replace Request

Use this form to Void/Replace a service that has been claimed and/or denied.

Complete information in the table below and send to Behavioral Health Administration, 1340 Arnold Drive, Suite 200, Martinez, CA 94553, **FAX (925) 957-5156. Include a copy of the ShareCare Service Entry Screen**

☐ **VOID ONLY -** No corrections or updates needed.

☐ **VOID/CORRECTION -** Corrections to the service, i.e., replacement service

☐ **MEDI-CAL 835 DENIAL**

Reason for Request: ______________________________

Program Name: ______________________________

Reported By: ______________________________ **Date:** ______________

VOID			CORRECTION		
Consumer Service ID			DELETE SERVICE? ☐YES ☐NO		
CONSUMER ID			CONSUMER ID		
CONSUMER NAME			CONSUMER NAME		
FACILITY ID			FACILITY ID		
PROGRAM ID			PROGRAM ID		
PROVIDER ID			PROVIDER ID		
PROVIDER TIME			PROVIDER TIME		
BEGIN DATE			BEGIN DATE		
SERVICE CODE			SERVICE CODE		
PLACE OF SERVICE			PLACE OF SERVICE		
PREGNANCY INDICATOR	☐YES	☐NO	PREGNANCY INDICATOR	☐YES	☐NO
EMERGENCY INDICATOR	☐YES	☐NO	EMERGENCY INDICATOR	☐YES	☐NO

Comments:

CHECK IF APPLICABLE (one box only):

☐ Consumer Address Updated – Rebill Medi-Cal

Duplicate Override:

☐ Distinct Procedural Service

☐ Repeat Procedure by Same Person

☐ Repeat Procedure by Different Person

FOR BHA DEPT. USE ONLY

Complete Date: ______________

Verify Date: ______________________________

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