CONTRA COSTA
Behavioral Health Services
Mental Health Administration

Contra Costa Mental Health Plan

Insurance/Medicare Verification Notification Form

****** PLEASE COMPLETE FORM AND EMAIL to: MHBilling@hsd.cccounty.us ******

Complete this form at intake/registration and email to Contra Costa County Patient Accounting at MHBilling@hsd.cccounty.us or fax them to (925) 372-5115 as soon as insurance is verified. Please send any questions to MHBilling@hsd.cccounty.us. Email using an encrypted file format.

Date: _____ (mm/dd/yyyy) Completed by: _____

Organization: _____

Phone #: _____ ext. _____ Fax #: _____

Medical Record: _____ RU #: _____

Client Name: _____ (Last First M.I.) Sex: _____

Date of Birth: _____ (mm/dd/yy) Social Security No: _____

Date(s) of Service: _____

Insured Name: _____ (Last First M.I.)

Policy Number: _____ Effective Date: _____ (mm/dd/yyyy)

Group Number: _____ Effective Date: _____ (mm/dd/yyyy)

Insurance Company Name: _____

Billing Address: _____ (Street Address)

City: _____ State: _____ Zip Code: _____

Phone #: _____ ext. _____ Fax #: _____

BENEFITS VERIFIED WITH

Ins. Contact Name: _____ Phone #: _____ ext. _____

AUTHORIZATION VERIFIED WITH

Ins. Contact Name: _____ Phone #: _____ ext. _____

Authorization Number: _____

Effective Date: _____ Expiration Date: _____

Comments: _____

_____

For Patient Accounting Use Only

Date Received: _____ Entered by: _____

Notes: _____