CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Contra Costa Mental Health Plan
Insurance/Medicare Payment Notification Form

****** PLEASE COMPLETE FORM AND EMAIL to: MHBilling@hsd.cccounty.us, OR FAX TO (925) 372-5115******

Complete this form and email with supporting documents to Contra Costa County Patient Accounting at MHBilling@hsd.cccounty.us using an encrypted file format or fax to (925) 372-5115 one week from receipt of payment/denial or 90 days after insurance claim submission. For questions regarding the completion of this form, please call (925) 313-6551.

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

Organization : _____

Organization Phone #: _____ ext. _____ Organization Fax #: _____

Medical Record Number (PSP/ShareCare): _____ RU #: _____

Client Name:_____ Gender: _____
(Last, First, MI)

Date of Birth: _____ Social Security #: _____
(mm/dd/yyyy)

Insurance Company Name: _____

File Name (For Medi-Cal Denials): _____

SUPPORTING DOCUMENTATION

Check the box next to the type of insurance payment/denial notification document received (for this client only), and indicate the date and number of pages; attach document to this form.

	Document	RA/EOB/Denial Date	# Of Pages	Check/ EFT#
☐	Remittance Advice (RA)	_____	_____	_____
☐	Explanation of Benefits (EOB)	_____	_____	_____
☐	Denial Letter	_____	_____	_____

☐ I attest that this service meets the ADP 90 Day Insurance Billing Rule

Delegate
Signature/Title : _____ Date : _____

Phone #: _____ ext. _____

☐ Minor Consent Service

Comments:

For Patient Accounting Use Only Payment Posting Date: _____ Entered By: _____

Notes: