Contra Costa Behavioral Health Services
Mental Health Plan
Insurance/Medicare Verification Notification

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

Date (mm/dd/yyyy): ____________________ Verified by: ____________________________________

Organization: ____

Organization Phone No.: ___________________ ext. _______ Fax No.: __________________________

ShareCare Consumer ID: ___________________ Facility/Program ID: _______________

Client Name: ____________________________ _______________________ _____ Gender: _________

Last First M.I.

Date of Birth (mm/dd/yyyy): _________________ 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 Street Address: ____

City: ________________________________ State: _______ Zip Code: _________________

Phone: _________________________________ Ext. _______ Fax: _______________________

BENEFITS VERIFIED WITH

Ins. Contact Name: ________________________________ Phone No. _______________ Ext. _______

AUTHORIZATION VERIFIED WITH

Ins. Contact Name: ________________________________ Phone No. _______________ Ext. _______

Authorization Number: ____________________________ Effective Date: ________________ Expiration Date: ________________

Comments:

____

For Patient Accounting Use Only:

Date Received ________________ Verified by: ____

Notes: ____

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