

Contra Costa Mental Health Plan  
Insurance/Medicare Verification Notification Form

\*\*\*\* PLEASE COMPLETE FORM AND EMAIL to: [MHBilling@hsd.cccounty.us](mailto:MHBilling@hsd.cccounty.us) \*\*\*\*

Complete this form at intake/registration and email to Contra Costa County Patient Accounting at [MHBilling@hsd.cccounty.us](mailto: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](mailto:MHBilling@hsd.cccounty.us). Email using an encrypted file format.

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Date: \_\_\_\_\_ Completed by: \_\_\_\_\_  
(mm/dd/yyyy)

Organization: \_\_\_\_\_

Phone #: \_\_\_\_\_ ext. \_\_\_\_\_ Fax #: \_\_\_\_\_

Medical Record: \_\_\_\_\_ RU #: \_\_\_\_\_

Client Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Last First M.I.

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

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: _____

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