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

Complete this form and email with supporting documents using an encrypted file format to Contra Costa County Patient Accounting at MHBilling@cchealth.org, 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: _____ **(mm/dd/yyyy)** Billing Completed by: _____

Organization: _____

Organization Phone No.: _____ ext. _____ Fax No.: _____

ShareCare Consumer ID: _____ Facility/Program ID: _____

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

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

Insurance Company Name: _____

835 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 No.: _____ ext. _____

☐ Minor Consent Service

Comments:

For Patient Accounting Use Only

ShareCare Posting Date: _____ Entered By: _____

Notes: