CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

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.: _____

ccLink Medical Record Number: _____Bill Area 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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