

PAYOR FINANCIAL INFORMATION

Client: Name:
Financial Class: Effective Date:
Medi-Cal No: Medicare No:
Coverage Type:

MEDICARE PRESCRIPTION DRUG PLAN

INSURANCE INFORMATION

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize County San Mateo to release to the insurance company named above that information required for the purpose of filing a medical claim to receive reimbursement for services rendered by County Mental Health Services. Information to be released is limited to that requested and not to exceed a general description of the services rendered including dates and duration of visits, diagnosis and clinician's name.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been initiated in reliance hereon.

I further hereby authorize the above insurance company to pay directly to the San Mateo County Mental Health Department, or its authorized community mental health agent, any benefits otherwise payable to me for services beginning 07/2008 rendered but not to exceed the actual cost and/or the reasonable customary charges for such services.

Signature of Patient
(parent, if minor)

Signature of Policyholder
(if other than patient)

Date _____

COUNTY OF SAN MATEO
MENTAL HEALTH SERVICES DIVISION

225 W 37th Avenue
San Mateo, CA 94403
Telephone (650) 573-2324

LONG TERM MEDICARE ASSIGNMENT

By signing this form you will permit us to bill Medicare on your behalf. No billing on your part will be necessary.

"I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Mental Health Services of San Mateo County for any services furnished me by that physician/supplier. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

You will be expected to pay the lower amount of either what Medicare requires or the sliding fee established for you by County Mental Health Services.

Name: _____

HIC # _____

Provider # _____ Chart # _____

Signature

Date

MEDICARE
Medicare Secondary Payer Unit
Chico, CA 95976

Name: _____ Provider #: _____

HIC Number _____ MHS #: _____

Address: _____

1. Are you currently covered by an Employer Group Health Plan?

Yes _____ No _____

If yes, please complete questions 2 through 6.

2. Does the employer have 100 or more employees or belong to an association which has at least one member who has 100 or more employees? Yes _____ No _____ Unknown _____

3. If you answered yes or unknown to question 2, complete the following:

Name of Insurer: _____

Address: _____

Name of Group Health Plan: _____

Policy Number: _____ Effective Date: _____

Address of Group Health Plan: _____

Name of Employer: _____

Address of Employer: _____

Telephone Number of Employer: _____

4. Are you currently receiving benefits from the group health plan of your spouse or other family member who is an employee or self-employed individual? Yes _____ No _____

5. If you answered yes to question number 4, does the employer have 100 or more employees or belong to an association which has at least one member who has 100 or more employees?

Yes _____ No _____ Unknown _____

6. If you answered yes or unknown to question number 5, please complete the following:

Name of Insurer: _____

Address of Insurer: _____

Name of Group Health Plan: _____

Policy Number: _____

Name of Policy Holder: _____

Relation of policyholder to you: _____

Signature

Date