Contract Agency Payor Financial Form

Agency Name:	**Agency Number:**

Client ID (*Do name search):*	**Client Date of Birth (Required):**	**SSN (Required):**

Last Name:	**First Name:**	**M.I.**

Alias or other names used:

Does Client have Medi-Cal? ☐ Yes ☐ No **Share of Cost Medi-Cal?** ☐ Yes ☐ No

Client's Medi-Cal Client Index Number *(CIN Number)*? _____

Please attach copy of Meds Lite screen. If client has Full Scope Medi-Cal and no other insurance coverage, skip the remaining sections of this form and fax to MIS/Billing Unit (650) 573-2110.

Is client potentially eligible for Medi-Cal benefits? ☐ Yes ☐ No Client referred to Medi-Cal? ☐ Yes ☐ No

Date of Referral: _____ **Is this a Court-ordered Placement?** ☐ Yes ☐ No

Does Client have Medicare? ☐ Yes ☐ No

If yes, please check all that apply ____Part A ____Part B ____Part D

What is the Client's Medicare Beneficiary Number (*MBI Number*)? _____

Signed Assignment of Benefits? ☐ Yes ☐ No **Please attach copy of Medicare card**

Responsible Party's Information (Guarantor):

Name: _____ **Phone:** _____

Relationship to Client: _____ ☐ **Self**

Address: _____ City**:** _____

State: _____ Zip **Code:** _____

☐ **Refused to provide Financial Information and will be charged full cost of service.**

3rd Party Health Insurance Information

Health Plan or Insurance Company (Not employer)

Company Name: _____ **Policy Number:** _____

Street Address: _____ **Group Number:** _____

City: _____ Name **of Insured Person:** _____

State: _____ **Zip:** _____ **Relationship to Client:** _____

Insurance Co. phone number: _____ **SSN of Insured Person (if other than client):** _____

Please attach copy of insurance card *(front & back)* **Signed Assignment of Benefits?** ☐ Yes ☐ No

Does the client have HealthWorx Insurance? ☐ Yes ☐ No If Yes, please attach copy of insurance card *(front & back)*

Client Authorization

I affirm that the statements made herein are true and correct. I understand that I am responsible for paying the UMDAP liability amount or cost of treatment received by myself or by members of my household during each 1-year period. If the cost of service is more that the UMDAP liability amount, I will pay the lesser amount. It is my responsibility, and I agree to provide verification of income, assets and expenses. If I do not authorize, I will be billed in full for services received. I authorize San Mateo County Mental Health to bill all applicable mental health services to Medi-Care and/or my insurance plan, including any services provided under 26.5. I authorize payment of healthcare benefits to San Mateo County Mental Health.

_____ _____

Signature of Client or Authorized Person Date

Client refused to sign Authorization: ☐ Please check, if applicable Date: _____ Reason_____

Name of Interviewer: _____ Phone Number: _____ Best time to contact_____

Fax completed copy to: MIS/Billing Unit (650) 573-2110