



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) 608-9942.

Date: _____ Billing Completed by: _____
(mm/dd/yyyy)

Organization: _____

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

ccLink Medical Record Number: _____ Bill Area ID: _____

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

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

Insurance Company Name: _____

835 Denial- Request claim resubmission

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#
<input type="checkbox"/> Remittance Advice (RA)	_____	_____	_____
<input type="checkbox"/> Explanation of Benefits (EOB)	_____	_____	_____
<input type="checkbox"/> Denial Letter	_____	_____	_____
<input type="checkbox"/> 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

ccLink Posting Date: _____ Entered By: _____

Notes:

This document may contain protected health information only for use by the intended recipients. Any use, distribution, copying or disclosure by any persons other than the intended recipient is strictly prohibited and may be subject to civil action and or/ criminal penalties. Please email using a secure encrypted file format.