County of San Diego
Health and Human Services Agency

ASSIGNMENT OF INSURANCE BENEFITS FORM

I/We _____ Client Medical Record # _____

Policyholder _____ Relationship to Client _____

I do hereby assign to the agency contracted by the County of San Diego, any covered Insurance Benefits payable. (Please refer to your insurance policy or contact your insurance agent for assistance in completing the following.)

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

POLICY NUMBER _____ CERTIFICATE/MEMBERSHIP NUMBER _____

EFFECTIVE DATE _____ ENROLLMENT CODE _____

CLIENT BIRTHDATE _____ CLIENT SOCIAL SECURITY NUMBER _____

POLICYHOLDER'S SOCIAL SECURITY NUMBER _____ POLICYHOLDER DOB _____

UNION LOCAL NUMBER _____

PLEASE SIGN IN BOTH PLACES BELOW

FOR GROUP INSURANCE

Insurance companies must have the following information, in addition to any of the above that may apply, before payment on insurance claim can be made.

Name of Employer _____

Address of Employer _____

Group Policy Number _____ Certification/Membership Number _____

I understand and agree that I/We are responsible to notify my Insurance carrier of out of plan services received. By signing this form, you are giving permission for all Contract Providers for the County of San Diego, to bill your insurance for services rendered.

Date _____ Client Signature _____

Date _____ Policyholder's Signature _____

County of San Diego
Health and Human Services Agency

ASSIGNMENT OF BENEFITS

Client: _____

Medical Record/Client ID #: _____

Program: _____

HHSA: BHS/SUD F108 (05/2019)