County of San Diego

Health and Human Services Agency

Mental Health Services

**ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**I/We\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient M.R. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policyholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I do hereby assign to the County of San Diego, or agencies 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPANY ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CERTIFICATE/MEMBERSHIP NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EFFECTIVE DATE\_\_\_\_\_\_\_ENROLLMENT CODE \_\_\_\_\_\_\_\_\_\_\_\_PATIENT’S BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S SOCIAL SECURITY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICYHOLDER’S SOCIAL SECURITY NUMBER Policy Holder DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UNION LOCAL NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***LEASE 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 the County of San Diego or Contracted Agency for all charges not paid by this agreement or as determined by Uniform Method of Determining Ability to Pay (UMDAP).

I/We authorize the release of information regarding care received at the County of San Diego Mental Health Services or a Contracted Agency in San Diego County, as requested by the Insuring Agency.

By signing this form, you are giving permission for all mental health programs provided by the County of San Diego, or its Contract Providers, to bill your insurance for services rendered. A copy of this release will be forwarded to each program within the County of San Diego from which you receive services.

Date Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_ Policyholder’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| County of San DiegoHealth and Human Services AgencyMental Health Services**ASSIGNMENT OF BENEFITS**HHSA: MHS-071 (03/2006) | **Client:** **MR/Client ID#:** **Program:**  |