Monterey County Health Department Behavioral Health Division
Private Insurance and Medicare Billing Authorization

(_____) **MEDICARE (initial if you are covered by Medicare)**

I request that payment of authorized Medicare benefit be made to the Monterey County Health Department, Behavioral Health Division for any services they furnished me. I authorized any holder of medical information about me 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 medication information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based on the charge determination of Medicare Carrier.

(_____) **PRIVATE INSURANCE (initials if you are covered by private insurance)**

I authorize payment of medical benefits, otherwise payable to me, to the Monterey County Health Department, Behavioral Health Division for all the services they provide. I understand that I am financially responsible to the Monterey County Health Department, Behavioral Health Division for charges not covered by this assignment. I authorize Monterey County Health Department Behavioral Health Division to release to my insurance company any medical information for processing of a claim. I authorize Monterey County Health Department Behavioral Health Division to obtain information pertaining to my insurance coverage and benefits from the carrier of same. I permit a copy of this authorization to be used in place of the original.

Coverage Detail

Medicare Number: _____ Part A Effective Date: ___/___/____

Part B Effective Date: ___/___/____

Private Insurance Information

Insurance Company Name: _____ Group Number: _____

Address: _____ Policy No: _____

_____ _____ _____ Effective Date:___/___/_____

Insured Name: _____ Insured SSN: ___ ___ _____

Client Relationship to Insured:_____ Insured Date of Birth: ___/___/___

Employment Related? ☐ Yes ☐ No Insured Gender ☐ Male ☐ Female

_____

Client Signature Date

Client Name:_____ Client Record Number: _____