SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

# Authorization and Assignment of Benefits

BHRS - Provider Billing - 2000 Alameda de Las Pulgas, Suite, 280, San Mateo, CA 94403

**Confidential Patient Information:** See California Welfare and Institutions Code Section 5328.

Client Name: Client No.:

## Release of Information and Assignment of Insurance Benefits

I hereby authorize the County of San Mateo to release information to my insurance companies that is required for the purpose of filing a medical claim to receive reimbursement for services rendered by County Behavioral Health and Recovery Services. Information to be released is limited to that requested and not to exceed a general description of the services rendered including dates and duration of visits, diagnosis and clinician's name.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been initiated in reliance hereon.

I further hereby authorize the insurance companies to pay directly to San Mateo County Behavioral Health and Recovery Services, or its authorized community mental health agent, any benefits otherwise payable to me for all services rendered but not to exceed the actual cost and/or the reasonable customary charges for such services.

**In the event that I receive a check from my insurance company, I agree to endorse the check and forward it to San Mateo County BHRS at the address listed above.**

Signature of Patient / Insured / Guardian _____ Date _____

## Medicare Assignment

By signing this form you will permit us to bill Medicare on your behalf. No billing on your part will be necessary. I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Behavioral Health and Recovery Services of San Mateo County for any services furnished to me by that physician/supplier. I authorize any holder of medical information 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 medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim is completed, my signature authorizes releasing of the information to the insurer. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-pay, and non-covered services. Co-pay and deductible are based upon the charge determination of the Medicare carrier.

You will be expected to pay the lower amount of either what Medicare requires or the sliding fee established for you by County Mental Health Services.

Signature of Patient / Guardian _____ Date _____