

ALAMEDA COUNTY MENTAL HEALTH PLAN BENEFICIARY REGISTRATION DATA FORM

| | | |
|-------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> CFS | <input type="checkbox"/> CALWORKS | <input type="checkbox"/> MIA |
| <input type="checkbox"/> HEALTHYFAM | <input type="checkbox"/> MICHILD | <input type="checkbox"/> MEDI-CAL |

The following information must be provided to the Alameda County Mental Health Plan, either by the beneficiary or by the provider, to the site that is the first point of contact with the plan:

REFERRAL/PRIOR REVIEW
ACCESS Program
2035 Fairmont Dr.
San Leandro, CA 94578
FAX (510) 346-1083
Phone 1-800-491-9099

EXTENDED REVIEW
Authorization Services
2000 Embarcadero Suite 400
Oakland, CA 94606
FAX (510) 567-8148
Phone (510)567-8141

CLAIMS
Claims Processing Center
P.O. Box 738
San Leandro, CA 94577-0738
FAX ((510) 567-8081
Phone (510) 567-8032 or 1-800-878-1313

| | | | |
|--|---------------------------|--|---------------------------------|
| CLIENT LAST NAME | FIRST NAME | MI | GEN Jr., Sr. |
| ALIAS LAST NAME | FIRST NAME | MI | GEN Jr., Sr. |
| BIRTH LAST NAME | FIRST NAME | MOTHER FIRST NAME | |
| ADDRESS | CITY | ZIP CODE | PHONE # |
| SSN: ____/____/____ | PRIMARY LANGUAGE: * ____ | SECONDARY LANGUAGE: * ____ | |
| D.O.B.: ____/____/____ | PRIMARY ETHNICITY: * ____ | SECONDARY ETHNICITY: * ____ | |
| SEX: <input type="checkbox"/> M <input type="checkbox"/> F | EDUCATION: ____#YRS | PRESENTING PROBLEM: * ____ (OTHER THAN MENTAL HEALTH) | PHYSICAL DISABILITY: * ____ |
| MARITAL STATUS: SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER <input type="checkbox"/> ____ | | | BIRTH PLACE: * ____, ____, ____ |

*Use letter or number code from key on backside:

| | |
|---|--|
| IF CHILD LIVES WITH: PARENT <input type="checkbox"/> RELATIVE <input type="checkbox"/> PLACEMENT <input type="checkbox"/> ____ | |
| NAME: _____ | WORK #: _____ |
| CONTACT PERSON: _____ | CWW <input type="checkbox"/> P.O. <input type="checkbox"/> GUARDIAN/CONSERVATOR <input type="checkbox"/> PARENT <input type="checkbox"/> |
| PHONE #: _____ | S.W. STAFF #: _____ |
| PROVIDER NAME/REFERRAL SOURCE | RU # |
| ADDRESS | PHONE # FAX # |

| INSIDE DOUBLE BORDERS FOR MENTAL HEALTH PLAN ADMINISTRATION USE ONLY: | |
|---|-----------------------------------|
| TODAY'S DATE: | REVIEWER: STAFF #: |
| MEDI-CAL NUMBER: | MEDICARE NUMBER: |
| OTHER INSURANCE: | PART A EFF: PART B EFF: |
| MEDI-CAL ADDRESS: | |
| ELIGIBILITY VERIFIED <input type="checkbox"/> COMMENTS: | COMPLETED BY: _____ |
| CLERICAL ENTERED BY: _____ / / DATE | CLINICAL ENTRY BY: _____ / / DATE |
| PSP CHECKED BY: _____ / / DATE | PSP #: _____ |