County of San Diego
Health and Human Services Agency

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 ADDRES _____
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 _____

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 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 or a Contracted Agency in San Diego County, as requested by the Insuring Agency.

By signing this form, you are giving permission for all 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 _____

County of San Diego
Health and Human Services Agency

ASSIGNMENT OF BENEFITS

HHSA: BHS-071 (03/2015)

Client: _____

MR/Client ID#: _____

Program: _____