Reset Form Print Form

Alameda County Behavioral Health Care Services
Provider Relations Department

MERGE REQUEST FORM

Date:	
Requested by:	
Organization Name:	
Reporting Unit #:	
Phone #	
Email Address:	

DUPLICATE CLIENTS' RECORD:

CLIENT #1

Name:	
Client # (INSYST)	
Account # (INSYST)	
ID # (ECURA) * **	
Date of Birth:	
SSN:	
Gender:	F
Mother's First Name	
Do you use Clinicians Gateway?	☐ YES ☐ NO
Is this a Sub-Payee Client?	☐ YES ☐ NO

CLIENT #2

Name:	
Client # (INSYST)	
Account # (INSYST)	
ID # (ECURA)* **	
Date of Birth:	
SSN:	
Gender:	F
Mother's First Name	
Do you use Clinicians Gateway?	☐ YES ☐ NO
Is this a Sub-Payee Client?	☐ YES ☐ NO

***** ID # is required FOR DUPLICATE RECORDS IN ECURA.**

Comments: _____

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Please fax completed form to Jesusa Santos, Provider Relations Representative at (510) 567-8081. For questions call (510) 777-2144 or 32144.

(To be completed by the Provider Relations Office)

Date Completed:	**Type of Action Taken:**
	o **Merge Not Required** o **Client Numbers Merged** o **Account Number Merged** o **Client/Account Number Merged**

Revised by JCS on 5/14/2009