ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

Beneficiary Registration For Prior Consultation

ACCESS PROGRAM
1900 EMBARCADERO COVE, SUITE 208
OAKLAND, CA 94606
PHONE 1-800-491-9099
FAX: (510) 346-1083

The following information must be filled out by the provider.
Forward this completed form, along with the Request For Prior Consultation, to the ACCESS Program at the above address.
For Boxes 1- 10, use CSI codes (See the INSYST Table of Codes for CSI codes).

CLIENT LAST NAME	FIRST NAME	MI	GEN Jr., Sr.
1. ALIAS LAST NAME	FIRST NAME	MI	GEN Jr., Sr.
BIRTH LAST NAME	FIRST NAME	MOTHER FIRST NAME	
2. ADDRESS / CITY / ZIP CODE		PH # _____ ALT PH #	

SSN:_____-_____-_____	3: EDUCATION: __ __	4: PHYSICAL DISABILITY: __ __
D.O.B: _____-_____-_____	5: PRIMARY LANGUAGE: __	5: PREFERRED LANGUAGE: __
SEX: M / F	6: ETHNICITY/RACE:__ __ __ __ __	7: HISPANIC ORIGIN: __
8: MARITAL STATUS: __	10: BIRTH PLACE: _____	
9: CARE GIVER UNDER 18: __ __ OVER 18:__ __	__ __ COUNTY __ __ STATE __ __ COUNTRY	

IF CHILD LIVES WITH: PARENT o RELATIVE o PLACEMENT o
CONTACT PERSON: _____ GUARDIAN/CONSERVATOR o PARENT o
PHONE #: _____

PROVIDER NAME/ADDRESS:	PHONE # FAX #

INSIDE DOUBLE BORDERS FOR MENTAL HEALTH PLAN ADMINISTRATION USE ONLY:

TODAY'S DATE: REVIEWER: STAFF #:

MEDS ADDRESS: _____ CIN #_____

MEDI-CAL #: _____ EFF. DATE: _____ BIC ISSUE: _____

MEDICARE #: _____ PART A: _____ PART B: _____

OTHER INS:

COMMENTS:

VERIFIED / COMPLETED BY: _____

INSYST #: _____

DATA ENTRY BY: _____ DATE / / CLINICAL ENTRY BY: _____ DATE / /

REVISED 02/21/07