Provider Request for Invoice Payment Delegation Form – Court Testimony

Invoicing for Court Testimony

This letter serves as a request for an Invoice Payment Agreement between Optum and on behalf of the County of San Diego Child and Family Well-Being for services rendered by: and License Choose to the following Client:

1. Child Information		
Child Name:	Gender: Choose	If Other:
DOB:	State ID Number:	
Caregiver's Name and Address (Including facility name, if any): (*Please note if the client is homeless, you should note the zip code where they most frequently are located*)		
Caregiver's Phone Number:		

2. Provider Information		
Provider/Agency Name:		
License Type:		
License Number:		
NPI Number:		
Business License Number:		
Telephone Number:		
Fax Number:		
Email:		
Office Address:		
City:	State:	Zip Code:

3. PSW/PSS Information
PSW Name:
PSW Phone Number:
PSW Email:
Region/Centralized Program:
PSS Name:
PSS Phone Number:
PSS Email:

4. Service Requested			
Service	**Cost**	**Court Date(s)**	**Comments Below**
☐ Half day (Up to four hours)	**$300**		☐
☐ Full day (Over four hours)	**$450**		☐
Comments:			

1. Provider is requesting Optum execute an Invoice Payment Delegation Agreement on their behalf to issue payment to provider:
   for services rendered to client:

2. Optum is not responsible for any clinical quality of care oversight, concerns or grievances with regards to services rendered by Provider. Optum Treatment Evaluation Resource Management (TERM) Oversight will not review any clinical work products related to services rendered by the Provider.

Your Signature Confirms Agreement with the Terms of this Agreement:

AGREED AND ACCEPTED

Provider Signature

_____

Name and Title

_____

Signature Date

Please submit this completed form <u>after the court date</u> via email or fax as follows:

- **Email:** sdu_providerserviceshelp@optum.com
  Subject Line: CFWB Request for Invoice Payment

- **Fax:** 877-309-4862
  Attention: CFWB Request for Invoice Payment

6. Provider Services Only	
Date Invoice Request Received:	Number of Days:
Date Agreement Sent to Provider:	
Date Agreement Returned by Provider:	
Date Agreement Executed:	
*Date to contact CWS for authorization extension, if applicable: (*Forty-five days prior to the authorization end date indicated in Section 4 above*)	