**SmartCare CLIENT PLAN REQUEST**

**Client Name & ID#:**

**Program Name:**

Client’s DOB (to verify):

Submitted By:       Date:

**New Client Plan**  **Update Existing Client Plan** (to indicate coverage change or expiration date)

**Check the coverage plan that applies to the client.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Health Plan** | **Insured ID (Policy#, CIN)** | **Effective Date** | Expiration Date |
| Choose an item. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Secondary Health Plan | Insured ID (Policy#, CIN) | Effective Date | Expiration Date |
| Choose an item. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TertiaryHealth Plan | Insured ID (Policy#, CIN) | Effective Date | Expiration Date |
| Choose an item. |  |  |  |

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| --- | --- | --- | --- | --- |
| Assignment/Release of Information obtained?  Yes  No | | | | |
| Coverage Plan (If ‘Other’ is checked): | | | | |
| Coverage Plan Mailing Address (If known): | | | | |
| **Client’s Relationship to Insured/Subscriber:** | | Choose an item. | | |
| **If Client’s Relationship to Subscriber is not equal to ‘Self’, provide info below, otherwise leave blank.** | | | | |
| Subscriber’s Name (Lastname, Firstname) | | | | |
| Subscriber’s Address: | | | | |
| Subscriber’s Sex: | Female | | Male | Unknown |
| Subscriber’s SSN: | | | Subscriber’s DOB: | |

**THIS SECTION FOR BHS/FISCAL BILLING UNIT ONLY**

**Coordinator of Benefits (COB):** System will automatically assign coordinator of benefits or benefit plan order based on industry standard. Monthly Medi-Cal Eligibility File (MMEF) Upload will insert a Medi-Cal MH and Medi-Cal DMC plan if client is Medi-Cal eligible. Unless otherwise told to do so, please DO NOT change COB order as this will directly impact where services will be billed.

1. Medicare
2. HMO
3. Medi-Cal
4. Default Plan

Completed By:       Date: