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| **REQUESTER:**   * **Use Form B to request duplicate client case numbers to be combined.** * **Only TYPED Forms will be accepted effective 05/15/2019.** * **Complete fields in each column as instructed.** * **Fax this form along with any supporting documents e.g. ID, Medi-Cal card, Immigration, Adoption.**   **\*Medical Policy & Effective date can be found in *Clinicians Homepage “Insurance Coverag*e” Tab** | | | | | | | | | | | | | | | | |
| **Section #1 - REQUESTER INFORMATION** | | | | | | | | | | | | | | | | |
| **Date of Request** | | /    / | | | | | **Form completed by:** | | | | |  | | | | |
| **Program Name** | |  | | | | | **Your Phone #** | | | | | **(**     **)**     **-** | | | | Ext # |
| **Unit/SubUnit #** | | / | | | | | **Your Fax #** | | | | | **(**     **)**     **-** | | | | |
| **Section #2 - CLIENT INFORMATION** | | | | | | | | | | | | | | | | |
| **CCI Data Fields- To find CCI - Right click on patient name, select “Show Core Client Information”)** | | | **Client Record A**  **As Data CURRENTLY Appears in the Core Client Information (CCI) window**  **Leave field blank if data not available** | | | | | | **Client Record B**  **As Data CURRENTLY Appears in the Core Client Information (CCI) window**  **Leave field blank if data not available** | | | | | | | |
| **Case Number** | | |  | | | | | |  | | | | | | | |
| **Sort Name** | | |  | | | | | |  | | | | | | | |
| **Client Name** | | |  | | | | | |  | | | | | | | |
| **Date of Birth (mm/dd/yyyy)** | | | /    / | | | | | | /    / | | | | | | | |
| **Social Security #** | | | -    - | | | | | | -    - | | | | | | | |
| **\*Medi-Cal Policy #/eff date (mm/dd/yyyy)** | | |  | | | /    / | | |  | | | | | /    / | | |
| **Remarks/ Add’l Information** | | |  | | | | | | | | | | | | | |
| **STOP – DO NOT ENTER INFORMATION BELOW THIS LINE. HIMS USE ONLY.** | | | | | | | | | | | | | | | | |
| **NOTICE TO REQUESTER:**  **Unable to Combine Clients** | | | | **Reason:** | | | | | | | | | | | | |
| **CLIENT INFORMATION TO BE KEPT IN CCBH** | | | | | | | | | | | | | | | | |
| **Case Number** |  | | | | | | | **Date of Birth** | | /    / | | | | | | |
| **Sort Name** |  | | | | | | | **Social Security #** | | -    - | | | | | | |
| **Client Name** |  | | | | | | | **Medi-Cal Policy # /eff date** | |  | | | | | /    / | |
| **Date completed by HIMS** | | | /    / | | | | | **HIMS Staff CCBH ID # and Name** | | | | |  | | | |
| **Sent to ASO** | | | | | **Sent to MHBU** | | | | | | **N/A** | | | | | |

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| --- | --- | --- | --- |
| **The section below to be completed by the Administrative Services Organization (ASO) staff only.** | | | |
| **Date ASO Combined Clients** | /    / | **ASO Staff who Combined Clients** |  |