Access Insurance Questionnaire

Date:

Place - Patient Label Sticker

Please read – important information regarding patient’s coverage.

Patient **does not have coverage** and *has decided not to be seen today.*

Patient **does not have coverage** and has decided to be seen. Patient is aware he/she will be billed. Clerk was not able to contact a Financial Counselor during the registration process. *Patient has been advised to contact the Financial Counseling Department. 1-800-771-4270*

Patient has Private **HMO/PPO coverage** and should be seen by his/her own network provider. *Patient does not want to be seen.*

Patient has Private **HMO/PPO coverage** and should be seen by his/her own network provider. *Patient would like to be seen by you and is aware he/she will be billed.*

Patient has a **Medi-Cal Managed Care Plan** and should be seen by his/her own network provider. *Patient does not want to be seen.*

Patient has a **Medi-Cal Managed Care** and should be seen by his/her own network provider. *Patient would like to be seen by you and is aware he/she will be billed.*

Patient has a **non CCHP** **Medicare Managed Care Plan** and should be seen by his/her own network provider. *Patient does not want to be seen.*

Patient has a **non CCHP** **Medicare Managed Care** and should be seen by his/her own network provider. *Patient would like to be seen by you and is aware he/she will be billed.*

**X**

**Patient should not receive a follow-up appointment without contacting the Financial Counseling Department at 1-800-771-4270. A CCHS Wallet Card has been provided to the patient.**

I acknowledge the information stated above.

Patient Signature Date

Nurse/Provider - place form in “Confidential” recycle bin

Revised 11.21.2013 lg