CalOptima Health

Consent and Agreement to Offset Monies Owed to CalOptima Health

Provider Name:	
NPI:	
Tax ID:	
Phone Number:	
Member Name:	
Member Account Number:	
Claim Number:	
Overpaid Amount:	
Date of Service(s):	
Reason of Consent to Offset Money *(Please Specify):*	

I am authorized to sign on behalf of the provider listed above and authorize CalOptima Health to offset the amount owed from future payments.

Name *(Please Print):*	
Title:	
Signature:	
Date:	