

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
VERIFICATION OF ABSENCE OF MEDI-CAL

Patient Name

M.I.S. Number

Date of Service: _____

DEPARTMENT OF MENTAL HEALTH IS NOT ABLE TO SECURE THE
DOCUMENTATION NECESSARY TO PROCESS THE CLAIM FOR MEDI-CAL.

Staff Person: _____

Clinic Manager: _____

Date: _____