CONTRA COSTA
ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

SUD/AOD SERVICE VOID & REPLACE REQUEST

This form should be used to Void/Replace a service that has been claimed.

Complete information in the table below - send to: 1220 Morello Avenue, Suite 101 Martinez, CA 94553, FAX (925)335-3311

**** Include copy of Sharecare Service Entry Screen**

☐ **VOID ONLY** No corrections or updates needed. ☐ **VOID/CORRECTION** Corrections to the service, i.e., replacement service

Reason for Request: _____

Program Name: _____

Reported By: _____ **Date:** _____

VOID		CORRECTION	
Client Service ID		**Remove if Service is Deleted ****	☐
CLIENT ID		**CLIENT ID**	
CLIENT NAME		**CLIENT NAME**	
FACILITY ID		**FACILITY ID**	
PROGRAM ID		**PROGRAM ID**	
PROVIDER ID		**PROVIDER ID**	
PROVIDER TIME		**PROVIDER TIME**	
BEGIN DATE		**BEGIN DATE**	
SERVICE CODE		**SERVICE CODE**	
PLACE OF SERVICE		**PLACE OF SERVICE**	
ICD-10 Code		**ICD-10 Code**	
CLIENT PREGNANT	☐ YES ☐ NO	**CLIENT PREGNANT**	☐ YES ☐ NO
EMERGENCY	☐ YES ☐ NO	**EMERGENCY**	☐ YES ☐ NO
Duplicate Override		☐ **Distinct Procedural Service** ☐ **Repeat Procedure by Same Person** ☐ **Repeat Procedure by Different Person**	

Comments:

FOR BHA DEPT. USE ONLY

Complete Date: _____

Verify Date: