MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

# CLAIM FORM
# for services provided outside the US

## INSTRUCTIONS

**Mail completed form and attachments to:**
Carelon Behavioral Health
PO Box 1852
Hicksville, NY 11802-1852

Use of Claim Forms:

1. A completed claim form is required for each bill submitted
2. The supplier should complete Part II or furnish an itemized bill
3. For hospital charges, include a copy of the itemized hospital bill.

How to Submit Itemized Bills:

1. All bills should include the employee's and patient's name, date and type of service, and the charge for each. Provider's bills should also include the type of treatment and diagnosis**. Cancelled checks and receipts are not acceptable**.
2. Please be sure you have provided the **employee's Social Security Number**.

**For claim or benefit information, call the Chevron/*Carelon Behavioral Health* Customer Service line at 1-800-847-2438**

## PART I TO BE COMPLETED BY EMPLOYEE

| 1. EMPLOYEE'S NAME | (LAST) | (FIRST) | |
|---|---|---|---|
| 2. EMPLOYEE'S ADDRESS | (STREET) | (CITY) | (STATE/PROVINCE) (ZIP /POSTAL CODE) |
| 3.EMPLOYEES SOCIAL SECURITY NUMBER | | | 4. EMPLOYEE'S PHONE NUMBER |

## PATIENT INFORMATION

| 5. PATIENT'S NAME | (LAST) | (FIRST) | (MIDDLE INITIAL) |
|---|---|---|---|

| 6. PATIENT'S BIRTHDATE MONTH / DAY / YEAR | 7. PATIENT'S SEX | 8 PATIENT'S RELATIONSHIP TO SUBSCRIBER | 9. DIAGNOSIS OR NATURE OF ILLNESS |
|---|---|---|---|
| | ☐ MALE ☐ FEMALE | ☐ SELF ☐ CHILD ☐ SPOUSE | |

## OTHER INSURANCE

10. IS THE **PATIENT** COVERED BY AN **OTHER** GROUP INSURANCE PLAN? (e.g. through patient's employer or through a previous marriage etc.) ☐ YES ☐ NO

| IF YES | NAME OF INSURANCE COMPANY | POLICY NUMBER |
|---|---|---|
| | ADDRESS OF INSURANCE COMPANY | PATIENT'S SOCIAL SECURITY NUMBER |

11. IS THE PATIENT ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

| IF YES | MEDICARE PART A EFFECTIVE DATE | MONTH | DAY | YEAR | MEDICARE PART B EFFECTIVE DATE | MONTH | DAY | YEAR |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**If the patient is covered under any other insurance, attach a copy of any bill(s) submitted to the carrier and the explanation of benefits form.**

12. HAS THE PROVIDER BEEN PAID? ☐ YES ☐ NO

13. IF CLAIM FOR DEPENDENT CHILD AGE 19 OR OVER, IS CHILD A FULL TIME STUDENT? ☐ YES ☐ NO

SCHOOL NAME _____

IS CHILD EMPLOYED? ☐ YES ☐ NO

**IF YOU WISH TO HAVE BENEFITS PAID DIRECTLY TO THE PROVIDER OF SERVICE PLEASE SIGN BELOW:**

AUTHORIZATION TO PAY PROVIDER. For service described, I hereby authorize payment of benefits, if any, to the named provider. I understand I am financially responsible for the charges not covered by this authorization.

EMPLOYEE'S SIGNATURE _____ DATE: _____

I certify that the information provided on this claim form is correct and complete and that I am claiming benefits only for charges actually incurred by the patient named, and hereby authorize any insurance company, organization, employer or provider of service to release any information with respect to this claim form.

**EMPLOYEE'S SIGNATURE** _____ DATE: _____

## PART II TO BE COMPLETED BY ATTENDING PROVIDER (or attach itemized statement)

Any person who knowingly and with intent to defraud provides any materially false or misleading information, commits a fraudulent act which is a crime.

| 1. DATE OF ILLNESS (FIRST SYMPTOM) | 2. DATE FIRST CONSULTED FOR THIS CONDITION | 3. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE DATES | 4. IF EMERGENCY, CHECK HERE ☐ |
|---|---|---|---|
| 5. DATE PATIENT ABLE TO RETURN TO WORK | 6. DATES OF TOTAL DISABILITY FROM / THROUGH | 7. DATES OF PARTIAL DISABILITY FROM / THROUGH | |
| 8. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY) | | 9. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES FROM / THROUGH | |
| 10. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) | | 11. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES: | |

12. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE NUMBERS 1, 2, 3 FTC, OR DX CODE

1.

2.

3.

13. DID THIS CONDITION RESULT FROM PATIENT'S EMPLOYMENT ☐ YES ☐ NO

ACCIDENT? ☐ WORK ☐ AUTO ☐ OTHER

| 14. A DATE OF SERVICE FROM | TO | B PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) | (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES | D. CHARGES | E. DIAGNOSIS CODE | F. DAYS OR UNITS | |
|---|---|---|---|---|---|---|---|---|
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| 15. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. I CERTIFY THAT THE STATEMENTS ABOVE APPLY TO THIS BILL AND ARE MADE A PART THEREOF | 16. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ☐ YES ☐ NO | 17. TOTAL CHARGE | 18. AMOUNT PAID | 19. BALANCE DUE |
|---|---|---|---|---|
| Signature Date<br>**LICENSE #** | 20. PROVIDER SOCIAL SECURITY NO. | 21. PHYSICIAN'S SUPPLIER'S, AND/OR GROUP NAME, FULL ADDRESS AND TELEPHONE NO. | | |
| 22. YOUR PATIENT'S ACCOUNT NO. | 23. PROVIDER EMPLOYER I.D. NO. | I.D. NO. | | |

PLACE OF SERVICE CODES:

- 1 - (H) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office
- 4 - (H) - Patient's Home
- 5 - - Day Care Facility (PSY)
- 6 - - Night Care Facility (PSY)
- 7 - (NH) - Nursing Home
- 8 - (SNF) - Skilled Nursing Facility
- 9 - - Ambulance
- 0 - (OL) - Other Locations
- A - (IL) - Independent Laboratory
- B - (ASC) - Ambulatory Surgical Center
- C - (RTC) - Residential Treatment Center
- D - (STF) - Specialized Treatment Facility
- E - (COR) - Comprehensive Outpatient Rehabilitation Facility