Claim for Reimbursement of Travel Expenses

Chevron Mental Health and Substance Use Disorder Plan

Important – Please read before filing

The related qualifying *behavioral health* claim for the covered service *must* be on file with and approved by Carelon *before* this claim for the reimbursement of transportation and/or lodging expenses will be processed. As a reminder, if the behavioral health service was received from a network provider, the provider will file a behavioral health claim for you. If the service was received from an out-of-network provider, it is your responsibility to file a behavioral health claim with Carelon. You can learn how to file a behavioral health claim or check the status of all claims:

- From your Carelon website account at **www.achievesolutions.net/chevron**
- By calling Carelon at **1-800-847-2438 (562-467-5531 outside the U.S.)**

Documentation Required

This travel benefit claim will be denied if all required information is not present.

- Member must include the related qualifying behavioral health claim information on this reimbursement request.
- A valid receipt must be submitted for each expense.
  - All receipts must be itemized and legible.
  - Itemization includes, but is not limited to: name, date, time, amounts, and purpose.
  - Credit card statements are not acceptable as documentation.
  - Remember to keep a copy of your claim form and itemized bills with your records.

Submission Instructions

- Submit your travel benefit claim as soon as possible after your related behavioral health claim is approved. At the latest, you must file a claim for the reimbursement of travel expenses no later than six months (by June 30) following the calendar year in which the covered service was provided. If you don't file a proper claim within this time frame, travel expenses for the related covered service will be denied. Refer to the summary plan description for more about claim filing limitations and exclusions.
- Remit copies of your itemized receipts, this completed travel benefit claim form, and any supporting documentation via **mail-in only:**

  Carelon Behavioral Health
  P.O. Box 1852
  Hicksville, NY 11802-1850
- The Member is responsible for the payment of services rendered.
- A separate claim form for each family member must be submitted**.**

All fields on the claim form *must* be completed as instructed below:

Part I - All sections (1-10) must be completed.

- Check YES in Part I section 11, **do not** sign section 11A.
- Sign Part I section 12 (Patient/Subscribers' Signature).

Part II complete Sections 4, 6 (A-G), 8, and 12.

- Please skip Sections 1, 2, 3, 5, 7, 9, 10, 11, 13.
- Section 4 - All claims must contain a medically accepted diagnosis.
- Section 6 - Complete all sections A-G.
  - Section A - Enter the date of service for treatment.
  - Section B - Enter the place of service code (99) Other Unlisted Facility.
  - Section C - Enter the procedure code- **S0215** for all services.
  - Section D - Written description of the services. Briefly indicate the type of service, i.e., travel, etc.
  - Section E - Enter the diagnosis received related to the services for this claim.
  - Section F - Number of services is one (1). Use a separate line for each date of expense and receipt.
  - Section G - Charges requested for reimbursement. For travel by car list the number of miles from your permanent residence to the treating facility.
- Section 8 - Enter the total charges for the reimbursement request.
- Section 12 - Provider/Facility name and address where treatment was received.

Your signature on this claim form attests to the accuracy and completeness of all information on the form, including the receipts, and that you acknowledge that any material omission or misrepresentation of facts may result in the denial of benefits, termination of coverage for you and your dependents and/or disciplinary action including and up to termination of employment. It also authorizes the release of your medical records by the provider to Carelon if necessary.

Mental Health / Substance Abuse Treatment

CLAIM FORM

PART I **TO BE COMPLETED BY EMPLOYEE/PATIENT**

1. PATIENT'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

2. PATIENT'S ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)

3. PATIENT'S ID NUMBER (*ON YOUR INSURANCE ID CARD*)

4. PATIENT'S BIRTHDATE			5. PATIENT'S SEX	6. PATIENT'S RELATIONSHIP TO SUBSCRIBER
MONTH	DAY	YEAR	☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ CHILD

7. EMPLOYEE'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

8. EMPLOYEE'S SOCIAL SECURITY NUMBER	8a. EMPLOYER NAME / GROUP NUMBER

OTHER MENTAL HEALTH OR SUBSTANCE ABUSE COVERAGE:

9. IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE PLAN? ☐ YES ☐ NO

IF YES	NAME OF OTHER INSURANCE COMPANY :	ID NUMBER:
	ADDRESS OF OTHER INSURANCE COMPANY	

10. 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 an Explanation of Benefits.

ASSIGNMENT OF BENEFITS:

11. HAS THE PROVIDER BEEN PAID FOR THESE SERVICES? ☐ YES **(If yes, do not sign 11a)** ☐ NO, **(If no, go to #11A)**

11A. 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 my contract with Carelon Behavioral Health.

PATIENT/SUBSCRIBER'S SIGNATURE: _____ DATE: _____

12. PATIENT/SUBSCRIBERS'S SIGNATURE

I certify that the information 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.

SIGNATURE: _____ DATE: _____

PART II **TO BE COMPLETED BY ATTENDING PROVIDER**

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. NAME AND LICENSE LEVEL OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY) ***OPTIONAL***

2. NAME AND ADDRESS OF FACILITY WHERE SERVICE RENDERED (IF OTHER THAN HOME OR OFFICE)	3. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES:
4. DIAGNOSIS OR NATURE OF ILLNESS, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE NUMBERS 1,2,3, ETC., DX CODE OR ICD10: 1. 2. 3.	5. DID THIS CONDITION RESULT FROM PATIENT'S EMPLOYMENT? ☐ YES ☐ NO ACCIDENT? ☐ YES ☐ NO ☐ WORK ☐ AUTO ☐ OTHER

6. A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE	D. DESCRIPTION OF PROCEDURE, SERVICES, AND SUPPLIES	E. DIAGNOSIS CODE	F. DAYS OR UNITS	G. CHARGES
?						
?						
?						

7. 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: SIGNATURE: _____ DATE: _____	8. TOTAL CHARGE	9. AMOUNT PAID	10. BALANCE DUE

13. PATIENT'S ACCOUNT NO.	11. PROVIDER SOCIAL SECURITY NO./ FED TAX ID NO. OR PROVIDER EMPLOYER I.D. NO.	12. PHYSICIAN'S SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER CARELON BEHAVIORAL HEALTH ID NO.:

For another copy of this form or instructions on how to complete, please visit **https://plan.carelonbehavioralhealth.com**.