Eligible participants may submit a behavioral health claim electronically to Beacon Health Options, regardless of where the services occurred.

To submit a claim, along with the provider's bill, etc. please go to the below URL, complete the required information and attach a completed claim form and the provider's bill within.

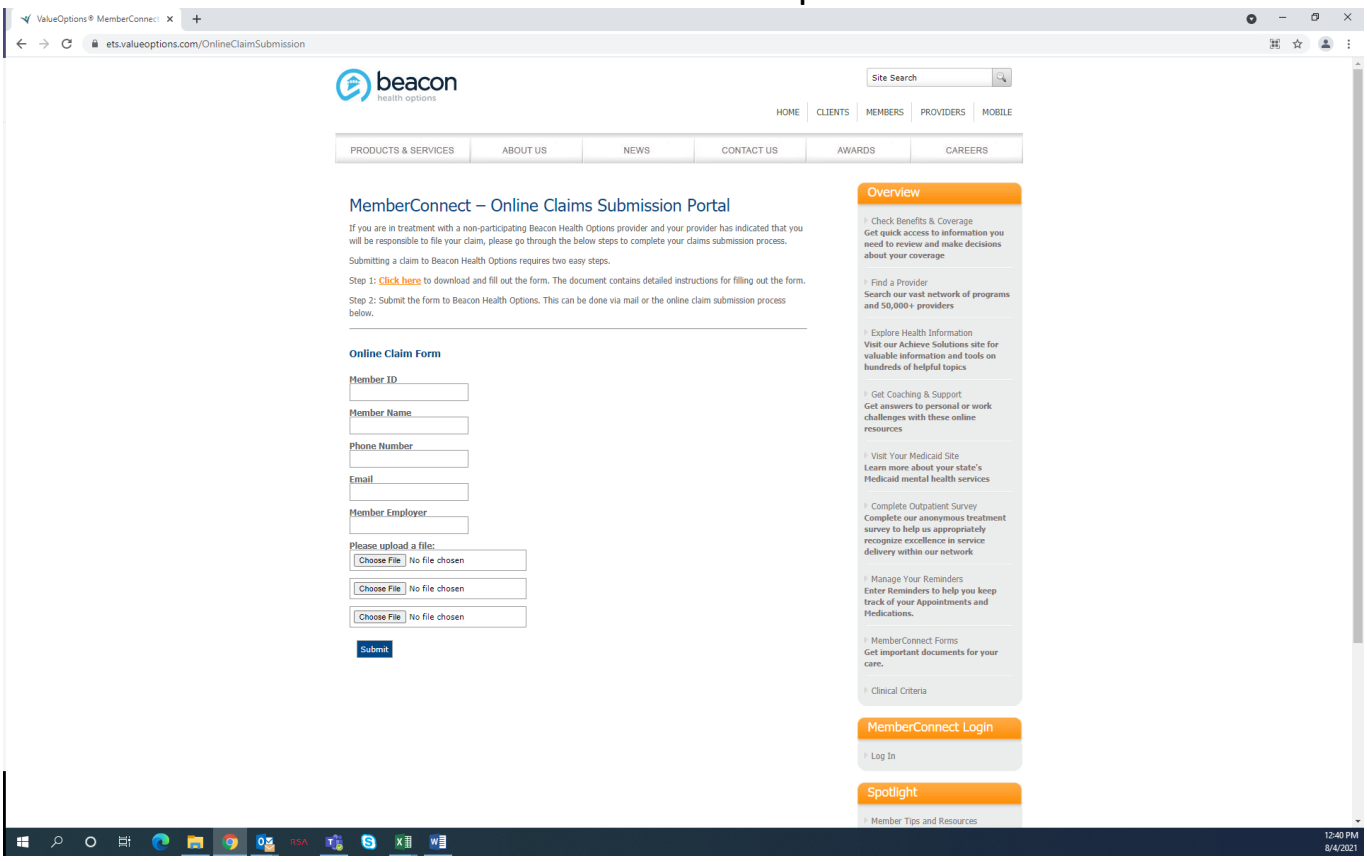
https://ets.valueoptions.com/OnlineClaimSubmission

Claims may also be mailed to this address:

Beacon Health Options
P.O. Box 1852
Hicksville, NY 11802-1850

*Please call Beacon at (800) 847-2438 to obtain your member ID or for further assistance in submitting your claim.

Screenshot of the member claims submission portal:



Mental Health / Substance Use Disorder Treatment Claim Form

DIRECTIONS FOR COMPLETION

If you are in treatment with a non-participating Beacon Health Options, Inc. (Beacon) provider and your provider has indicated that you will be responsible to file your claim, please take this claim form with you to your visit.

In order to facilitate payment of your claim, please be sure that Parts I and II are completed in their entirety. An explanation of each field is provided below. The fields in BOLD lettering are required in order for the claim to be considered for payment.

You must complete Part I in its entirety.

Your provider must complete Part II in its entirety. Even if your provider provides you with their custom claim form, Beacon requires that they complete Box 7 under Part II. If you are unable to get the signature of the provider, please print his/her name in Box 7, Part II. Please be sure that as much of Part II is completed as possible. You may attach your provider's custom claim form for our review.

Please make every effort to have this form printed in red ink. Please use a black ballpoint pen when filling in the required fields. This allows the claim to be scanned through technology that expedites the claims payment process. (However, black and white forms are accepted.)

PART I: To Be Completed By Employee/Patient (Required fields are in BOLD lettering)

1. PATIENT'S NAME - Enter the Patient's name (Last, First Name, and Middle Initial). Spell the name exactly as it appears on the subscriber/patient's identification card.

2. PATIENT'S ADDRESS - Enter the Subscriber/Patient's permanent address (Street, Apartment/PO Box Number, City, State, Zip Code).

3. PATIENT'S ID NUMBER - Enter the Subscriber/Patient's 9-digit ID number, or in the case of a dependent, the 11 digit ID number. This number appears on the Patient's insurance ID card.
Note: If this item is blank, the claim will be returned for this information.

4. PATIENT'S BIRTH DATE - Enter the Patient's date of birth.

5. PATIENT'S SEX - Put an X in the appropriate box to indicate the Patient's sex.

6. PATIENT RELATIONSHIP TO SUBSCRIBER - Put an X in the appropriate box to indicate the Patient's relationship to the Subscriber.

7. EMPLOYEE'S NAME - If different than Patient.

8. EMPLOYEE'S SOCIAL SECURITY NUMBER - Enter the Subscriber's Social Security Number (SSN) or Medicaid Number.

8a. EMPLOYER NAME/GROUP NUMBER - Enter the Subscriber's Employer name. If the Employer's group number is available on the card, please also provide.

OTHER MENTAL HEALTH/SUBSTANCE USE DISORDER COVERAGE
(This information is important if the Patient is covered under other group insurance. Even if the Patient is

not covered under other group insurance, please answer question #9.)

9. IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE PLAN? - Put an X in the appropriate box.

If there is no other insurance coverage, you do not have to answer the following questions:

- NAME OF OTHER INSURANCE COMPANY
- CARD NUMBER - This is the identification number assigned to the Subscriber by the other insurance company.
- ADDRESS OF OTHER INSURANCE COMPANY - Enter address of the other insurance carrier as it appears on the identification card.

NOTE: The other insurance carrier must be billed for these services. When you receive the Explanation of Benefits from the other insurance carrier, you should attach it to this claim form. Attach it even if the other insurance carrier does not pay anything on the services.

10. MEDICARE ELIGIBLE - Place an X in the appropriate box. If "Yes" complete the following:
PART A - EFFECTIVE DATE - Month, Day and Year PART B - EFFECTIVE DATE – Month, Day and Year

ASSIGNMENT OF BENEFITS
(This information is very important to assure any payment on the claim goes to the appropriate party, either to the member or the provider.)

11. HAS THE PROVIDER BEEN PAID - Put an X in the appropriate box. If you answer "Yes" to this question, please make sure that the amount paid is recorded in Box 9, Part II, Amount Paid.

11a. AUTHORIZATION TO PAY PROVIDER - The Subscriber should sign here if the provider is to be paid directly by Beacon. This should be signed by the Patient. If the Patient is an underage dependent, this should be signed by the Subscriber. If you have paid the Provider for these services, do not sign this section.

12. PATIENT/SUBSCRIBER'S SIGNATURE – This item must be signed by the Patient or Subscriber as verification that the services were rendered by the Provider listed on the form, and as authorization to release information.

PART II: To Be Completed By Attending Provider (Required fields are in BOLD lettering)

Note: If this form is not completed, claim form will be returned to the provider. If the provider will not complete Part II, please ask that he/she sign the form in Box 7. If the provider gives you another form as his/her bill for services, the same information as stated below must be on that form. Attach that form to this form for which you have completed Part I.

Beacon must have a current 1099 on file for the address to which this claim will be paid (box 12) . If you have not submitted a 1099 to Beacon in the past, please fax a copy to (757) 412-6425.

1. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE - The name and license level of the referring physician should be provided here. If you are the physician providing the service but you are not the referring physician, enter the name of the referring physician here. Leave blank if no referring physician.

2. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

3. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? - Check appropriate box.

4. DIAGNOSIS - All claims must contain a medically accepted diagnosis. Enter a valid

ICD-10-CM or DSM- 5 diagnosis code (including the fourth and fifth digits if applicable) that describes the principal diagnosis for the services rendered. There can be up to 3 diagnoses indicated. The primary diagnosis should be listed first.

5. CONDITION RESULTING FROM: CURRENT EMPLOYMENT – Place an X in the appropriate box. ACCIDENT AT WORK – Place an X in the appropriate box.

6. INFORMATION PERTAINING TO THE VISIT:

A. DATE OF SERVICE - Enter the "From" and "To" dates of service in MM/DD/YY (ex: 06/04/04) format. Claim line items can include no more than two dates of service for the same procedure code, unless the days are consecutive and the units coincide. Enter the number of units in 6F.

B. PLACE OF SERVICE - Enter the appropriate place of service code. A table of the valid codes is provided on the following page *(see Attachment A).*

C. PROCEDURE CODE - Enter the procedures, services, or supplies using most current CPT-4 or HCPCS codes, including modifiers, if any are necessary.

D. EXPLANATION OF SERVICES - This is the written description of the service/procedure indicated in 6C.

E. DIAGNOSIS CODE - Refer to the diagnosis entered in Box 4, Part II and indicate the most appropriate diagnosis for each procedure by using either 1, 2 or 3.

F. DAYS OR UNITS - Enter the number of services billed. For anesthesia, show the elapsed time in minutes.

G. CHARGES - Enter your usual or customary charge for the service/procedure rendered as indicated on each line.

7. SIGNATURE OF PHYSICIAN/SUPPLIER & DATE - Signature of Physician or Supplier including degree(s) or credentials and Date of Signature for the Provider rendering service. The actual signature, signature stamp or computer-generated signature of the physician is preferable. If you are unable to obtain this, please print the name of the Provider in this field.

8. TOTAL CHARGE - Enter the total charge for this claim. This is the total of all the charges for each service noted in Box 6G, lines 1-6.

9. AMOUNT PAID - If the answer to Box 9, Part I is "Yes", the amount paid by the other insurance carrier should be indicated in this block. The Explanation of Benefits from the other insurance carrier needs to be attached to the claim. If the Patient has paid for the charges being submitted on this claim form, please indicate the amount paid in this block.

10. BALANCE DUE - Enter the balance due for services listed on the claim form.

11. PROVIDER FEDERAL TAX ID NO. - Enter the Provider's 9-digit employer identification number (EIN) or social security number (SSN) under which payment for services is to be made for reporting earnings to the IRS. If the claim is to be paid to the Patient, the information in this field is not needed.

12. PHYSICIAN'S OR MEDICAL ASSISTANCE SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER & PROVIDER ID NUMBER - Enter the Provider's name, address, and telephone number. If applicable, please include the Beacon provider identification number.

13. PATIENT'S ACCOUNT NO. - Enter the unique number assigned by the Provider for the Patient.

Mental Health / Substance Use Disorder 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 BEACON ID NUMBER

4. PATIENT'S BIRTHDATE MONTH	DAY	YEAR	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ 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 USE DISORDER 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 Beacon Health Options.

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. If applicable	11. PROVIDER SOCIAL SECURITY NO./ FED TAX ID NO. OR PROVIDER EMPLOYER I.D. NO. For foreign claim, may leave blank	12. PHYSICIAN'S SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER BEACON HEALTH OPTIONS ID NO.: If applicable

ATTACHMENT A

HCFA 1500 REFERENCE MATERIAL

Place of Service Codes (Part II, Field B)

Code	Definition
02	Telehealth
03	School
11	Office
12	Home
21	Inpatient Hospitalization
22	Outpatient Hospitalization
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center/Free Standing
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mental Retardation
55	Residential Substance Use Disorder Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End – Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
82	Court
83	Correctional Facility
84	Other Community Setting
85	Drop-in Center
86	Foster Home
87	Place of Employment
99	Other Unlisted Facility