VALUEOPTIONS
Putting People First

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 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 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 ValueOptions.

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 ICD9: 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 VALUEOPTIONS ID NO.:

For another copy of this form or instructions on how to complete, please visit **http://www.valueoptions.com/members.htm**.