MENTAL HEALTH CLAIM FORM

Eligibility**:** HSBP employees including eligible dependents.

Maximum reimbursement allowed: $5000 per person, per benefit year. HSBP will reimburse 80% of the reasonable and customary provider charge not to exceed $200 per office visit, for a maximum reimbursement of $160 per visit. In no instance will HSBP reimburse the individual for more than what the individual is responsible for in copayments or coinsurance charges. In addition, in no instance will the maximum benefit per individual per benefit year exceed $5,000.

Claim Submission Rules:

- Entire claim form must be completed in full by participant or patient and eligible provider with the exact date(s), diagnosis, and procedure codes for which services were rendered. Eligible providers must be certified and licensed. Their degrees can be any one of the following: M.D., PhD., EdD., PsyD. (Doctor of Psychology). MSW (Master of Social Work) or CSW (Certified Social Worker).
- A separate claim form must be submitted per patient.
- All claims must be submitted to our office via fax or mail (contact info in letterhead) within one year from date of service. *Do not email claims*. Claims submitted after one year will be denied.

SECTION A: TO BE COMPLETED BY PARTICIPANT:

Participant's Name: _____ _____ Social Security No.: _____
(Last Name) (First Name)

Hospital where employed: _____ E-mail address:_____

Home Address: _____

_____ _____ _____
(City) (State) (Zip code)

Contact phone number: _____ Type (home, mobile, etc.) _____

SECTION B: TO BE COMPLETED BY PATIENT:

Participant's Name: _____ _____ Date of Birth: _____
(Last Name) (First Name)

Relationship to participant: _____

Address: _____ _____ _____ _____
(City) (State) (Zip code)

Other than medical coverage provided to the HSO by his or her employer and the House Staff Benefits Plan, is the patient also covered for benefits by any other Group Health Plan. ☐Yes ☐ No

If yes, please provide name of employer, organization or educational institution which provides this coverage:

_____

Address:_____

Name of Insurance Company: _____ Group Policy Number: _____

In order for this claim to be processed, the authorization below must be completed:

I authorize the release of any information necessary to process this claim (including information from physicians, providers of service, clinics, and all other agencies or insurance companies). This information, when required, may only be released to the House Staff Benefits Plan or its representatives.

Patient's Signature: _____ Date: _____

SECTION C: TO BE COMPLETED ONLY BY THE ATTENDING PROVIDER OF SERVICE:

Name of Physician: _____ _____Social Security No.: _____
(Last Name) (First Name)

Degree: _____ License No.: _____

Address: _____ _____ _____ _____
(City) (State) (Zip code)

Contact phone number: _____

Diagnosis:_____

_____

Diagnosis Code: _____ Date Patient first consulted you for this condition: _____

Complete Below or Attach Itemized Bills:

	Date of Service	Place of Service	Charges
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Indicate Place of Service:
OH - Out Patient Clinic In Hospital _____ O – Doctor's Office____ H – Patient's Home____ C – Clinic____

In order for this claim to be processed, the authorization below must be completed.

I hereby certify that the above statements are correct:

Signature of Physician or Provider or Service: _____ Date:_____

(05/13)