NYC 9/11 Benefit Program Claim Form

QualCare, Inc.
P.O. Box 1269
Piscataway, NJ 08855 - 1269
1-866-885-2895

PLEASE COPY THIS FORM AS NEEDED FOR ADDITIONAL REQUESTS
NOTE: PLEASE ATTACH BENEFICIARY'S INSURANCE E.O.B. (Explanation of Benefits) TO THIS FORM

BENEFICIARY INFORMATION

1. BENEFICIARY'S ID NUMBER

2. BENEFICIARY'S NAME (Last Name) (First Name) (Middle Initial)

3. BENEFICIARY'S BIRTH DATE
MM / DD / YY
____ /____ /_____.

3a. SEX
❑ M ❑ F

4. BENEFICIARY'S ADDRESS (No. Street)

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)

5. BENEFICIARY'S HEALTH INSURANCE – NAME OF PLAN

READ BACK OF FORM BEFORE COMPLETING and SIGNING THIS FORM

6. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

7. **INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

FRAUD STATEMENT
NOTICE: any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

8.	A DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B PLACE OF SERVICE	C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	D DIAGNOSIS CODE	E DAYS OR UNITS	F $$ CHARGES	G $$ AMOUNT INSURANCE PAID	H BENEFICIARY'S OUT-OF-POCKET $$ AMOUNT
1														
2														
3														
4														
5														

9. NAME OF THE HOSPITAL, FACILITY OR PROVIDER'S OFFICE (PLEASE PRINT)

10. TOTAL CHARGES
$ _____

11. TOTAL INSURANCE
$ _____

12. TOTAL BENEFICIARY
$ _____

13. FEDERAL TAX I.D. NUMBER SSN ❑ EIN ❑

14. PATIENT'S ACCOUNT NO.

15. LICENSE TYPE

16. LICENSE I.D.

17. STATE ISSUING LICENSE

18. LICENSE EXPIRATION DATE

19. SIGNATURE OF PHYSICIAN OR PROVIDER INCLUDING DEGREES OR CREDENTIALS

SIGNED _____ DATE _____

20. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than billing address)
Name: _____
Address: _____
_____

21. PHYSICIAN'S OR PROVIDER'S BILLING NAME, ADDRESS, ZIP CODE and PHONE #.

22. SUPERVISING PROFESSIONAL INFORMATION – FOR PROVIDERS WORKING UNDER A LICENSED AGENCY OR SUPERVISOR

_____ **NAME** (Please print)
_____ **LICENSE TYPE**
_____ **LICENSE I.D.**
_____ **TAX I.D. OR SS#**

_____
SIGNATURE

Instructions on How to Complete the NYC 9/11 Benefit Program Claim Form for Mental Health/Substance Use Services

Please submit claim invoices to: QualCare, Inc., P.O. Box 1269, Piscataway, NJ 08855-1269.

NOTE: This form should only be used to file claims for Mental Health and Substance Use Services. For reimbursement for prescription medication or laboratory work, please submit the following documents directly to QualCare: Receipts from your pharmacy, mail order supplier or medical lab. The pharmacy receipt must include the medication name and your out-of-pocket expenses for the medication, such as your co-payment or deductible. Pharmacy printouts that provide date, type of prescriptions and your expenses are also acceptable. Laboratory receipts must include the name of the lab, date of service, procedure code, charges, and diagnosis.

We want to process your claims as promptly as possible. To help us accomplish this on your behalf, please use this checklist as a guide to all the required information prior to submitting claims.

Top Three Reasons for Claims Processing Delays:

#1 Missing Explanation of Benefit (EOB)
#2 Missing provider signature
#3 Missing diagnosis or CPT code (procedure code)

INSTRUCTIONS FOR COMPLETING THE FORM:
The following is a brief description for each item and its applicability to requirements under the NYC 9/11 Mental Health and Substance Use Benefit Program. For additional information or inquiries please contact QualCare at 1866-885-2895.

Item 1. Enter the beneficiary's I.D.
Item 2. Enter the beneficiary's last name, first name, middle initial.
Item 3. Enter the beneficiary's date of birth (MM/DD/YYYY).
Item 3a. Check appropriate box for beneficiary's sex.
Item 4. Enter the beneficiary's address (street address, city, state, ZIP code, (telephone number optional).
Item 5. Enter beneficiary's Health Insurance and be sure to attach other Insurance Explanation of Benefit Statement to this Claim Form if the beneficiary has insurance.
Item 6. The signature of the beneficiary or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to beneficiary indicated.
Item 7. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.
Item 8. Column A: enter month, day and year (MM/DD/YYYY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).
Column C: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.
Column D: enter the diagnostic reference number to relate to the date of service and the procedure(s) performed to the appropriate ICD code (DSM IV code), or enter the appropriate ICD code (DSM IV code).
Column E: enter the number of days or units provided for each period in column A.
Column F: enter the total charge(s) for each listed service(s).
Column G: enter the insurance amount paid for each provided services, if applicable.
Column H: enter the beneficiary's total out-of-pocket costs.
Item 9. Enter name of the hospital facility or provider's office.
Item 10. Enter the total charge for the listed services in Column F.
Item 11. If any payment has been made, enter the amount here.
Item 12. Enter the balance now due.
Item 13. Enter the Federal Tax I.D.
Item 14. Provider may enter a patient account number that will appear on the remittance voucher.
Item 15. Enter provider's License Type.
Item 16. Enter provider's License I.D.
Item 17. Enter name of state issuing the license.
Item 18. Enter provider's license expiration date.
Item 19. Provider signature is required here.
Item 20. Enter complete name of hospital, facility or provider's office where services were rendered.
Item 21. Enter the provider's billing name and address.
Item 22. Enter supervising professional information: name, license type, license I.D., tax I.D. or SS#.

Place of Service (POS) Codes for Item 8:

11 Office
12 Patient Home
15 Mobile Unit
20 Urgent Care
22 Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgical Center
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center (CMHC)
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Ctr.
56 Psychiatric Residential Treatment Center
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service