Use this sample form, along with the DIRECTIONS FOR COMPLETION as a guide to completing your claim.

Mental Health / Substance Abuse Treatment

CLAIM FORM

PART I — TO BE COMPLETED BY EMPLOYEE/PATIENT

1. PATIENT'S NAME (LAST) Doo (FIRST) Scooby (MIDDLE INITIAL) D.
2. PATIENT'S ADDRESS (STREET) 196 Blessing Street (CITY) Anywhere (STATE) USA (ZIP CODE) 00000
3. PATIENT'S ID NUMBER (ON YOUR INSURANCE ID CARD) 334455667
4. PATIENT'S BIRTHDATE MONTH 6 DAY 14 YEAR 1906
5. PATIENT'S SEX ☒ MALE ☐ FEMALE
6. PATIENT'S RELATIONSHIP TO SUBSCRIBER ☒ SELF ☐ SPOUSE ☐ CHILD
7. EMPLOYEE'S NAME (LAST) Doo (FIRST) Scooby (MIDDLE INITIAL) D.
8. EMPLOYEE'S SOCIAL SECURITY NUMBER 112344596
8a. EMPLOYER NAME / GROUP NUMBER Massachusetts Institute of Technology

OTHER MENTAL HEALTH OR SUBSTANCE ABUSE COVERAGE:

...VERED BY ANY OTHER GROUP INSURANCE PLAN? ☒ YES ☐ NO

... OTHER INSURANCE COMPANY : Mr. Employer, Inc. ID NUMBER: (THIS IS THE NUMBER ON THE CARD FOR T... INSURANCE) CSDFWER

...F OTHER INSURANCE COMPANY 14 Smith Street, Venus, USA 12345

...LIGIBLE FOR MEDICARE? ☐ YES ☒ NO

...E PART A ...DATE MONTH DAY YEAR MEDICARE PART B EFFECTIVE DATE MONTH DAY YEAR

YES

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.

> If the patient is covered by Medicare, check "Yes" and attach a copy of the Medicare explanation of payment.

> If this box is marked, you need to provide an Explanation of Benefits from the other insurance company.

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 responsible for the charges not covered by my contract with ValueOptions.

...UBSCRIBER'S SIGNATURE: ______ DATE: ______

DO NOT SIGN if you are paying or have already paid the charges and the reimbursement check should come to YOU

.../SUBSCRIBER'S SIGNATURE

11 90804 Individual Therapy 1 1 65.00

...the information on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient na... ...any insurance company, organization, employer or provider of service to release any information with respect to this claim form.

SIGNATURE Scooby Doo DATE: 10/...

> You MUST sign this to verify that you did, in fact, receive services.

> If you have paid the doctor for the services in Box 8, Part II, listed below, DO NOT SIGN this area. This ensures that the payment will be made directly to you.

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
   Dr. Stephen Strange, MD
2. NAME AND ADDRESS OF FACILITY WHERE SERVICE RENDERED (IF OTHER THAN HOME OR OFFICE)
3. WAS LABORATORY WORK PERF... YOUR OFFICE? ☐ YES ☐ ... CHARGES: N/A
4. DIAGNOSIS OR NATURE OF ILLNESS, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE NUMBERS 1,2,3, ETC., DX CODE OR ICD9:
   1. 311.0
   2. 299.0
   3.
5. DID THIS CONDITION RESULT FROM PATIENT'S EMPLOYMENT? ☐ YES ☒ NO
   ACCIDENT? ☐ YES ☐ NO ☐ WORK ☐ AUTO ☐ OTH...

> This is called an ICD-9 code (diagnosis code). This information must be supplied by the provider.

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	CH...
01/05/04	01/05/04	11	90804	Individual Therapy	1	1	65...
01/06/04	01/09/04	11	90804	Individual Therapy	2	3	195...

> The number here refers to the number of the diagnosis code in Box 4, Part II.

> This is called the CPT code and must be supplied by the provider. It explains the type of service that was given.

...CIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. I CERTIFY THAT THE ...TS ABOVE APPLY TO THIS BILL AND ARE MADE A PART THEREOF:

Dr. Otto Octavius DATE: 9/25/05

8. TOTAL CHARGE	9. AMOUNT PAID	10. BALANCE DUE
$260.00	$260.00	$0.00

> This must be $0.00 if you have not signed Box 11a, Part I.

...NO. 345678DOO

11. PROVIDER SOCIAL SECURITY NO./ FED TAX ID NO. OR PROVIDER EMPLOYER I.D. NO. 847879623

12. PHYSICIAN'S SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER
    Sample Clinic, South Street
    Anywhere, USA 12345
    VALUEOPTIONS ID NO.:

For another copy of this form or instructions on how to compl...

> ValueOptions 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 ValueOptions in the past, please fax a copy to (757) 412-6425.