

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				2. PATIENT'S NAME (FIRST)			Scooby				
3. PATIENT'S NAME (MIDDLE INITIAL)			D.			4. PATIENT'S ADDRESS (STREET)			196 Blessing Street					
5. PATIENT'S ADDRESS (CITY)			Anywhere			6. PATIENT'S ADDRESS (STATE)			USA		7. PATIENT'S ADDRESS (ZIP CODE)		00000	
3. PATIENT'S ID NUMBER (ON YOUR INSURANCE ID CARD)					334455667					4. PATIENT'S BIRTHDATE				
MONTH		DAY		YEAR		5. PATIENT'S SEX		6. PATIENT'S RELATIONSHIP TO SUBSCRIBER						
6		14		1906		<input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input checked="" type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD						
7. EMPLOYEE'S NAME (LAST)			Doo				8. EMPLOYEE'S NAME (FIRST)			Scooby				
9. EMPLOYEE'S NAME (MIDDLE INITIAL)			D.			10. EMPLOYEE'S SOCIAL SECURITY NUMBER			R 112344596					
11. EMPLOYER NAME / GROUP NUMBER			Massachusetts Institute of Technology											

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.

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.

OTHER MENTAL HEALTH OR SUBSTANCE ABUSE COVERAGE:

COVERED BY ANY OTHER GROUP INSURANCE PLAN? YES NO

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

OTHER INSURANCE COMPANY 14 Smith Street, Venus, USA 12345

ELIGIBLE FOR MEDICARE? YES NO

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.

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.

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

SUBSCRIBER'S SIGNATURE: Scooby Doo DATE: 10/11

PROVIDER'S SIGNATURE: Dr. Stephen Strange DATE: 9/25/05

1. 90804 Individual Therapy 1 65.00

2. 90804 Individual Therapy 1 65.00

SIGNATURE: Scooby Doo DATE: 10/11

PART II TO BE COMPLETED BY ATTENDING PROVIDER

Any person who knowingly and with intent to defraud, provides 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 PERFORMED AT YOUR OFFICE? YES NO
CHARGES: N/A

4. DIAGNOSIS OR NATURE OF ILLNESS, 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? WORK AUTO OTHER

A. DATE OF SERVICE FROM	B. DATE OF SERVICE TO	C. PLACE OF SERVICE	D. PROCEDURE CODE	E. DESCRIPTION OF PROCEDURE, SERVICES, AND SUPPLIES	F. DIAGNOSIS CODE	G. DAYS OR UNITS	H. CHARGE
01/05/04	01/05/04	11	90804	Individual Therapy	1	1	65.00
01/06/04	01/09/04	11	90804	Individual Therapy	2	3	195.00

6. PROVIDER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. I CERTIFY THAT THE SERVICES ABOVE APPLY TO THIS BILL AND ARE MADE A PART THEREOF:
Dr. Otto Octavius DATE: 9/25/05

7. PROVIDER SOCIAL SECURITY NO. / FED TAX ID NO. OR PROVIDER EMPLOYER I.D. NO.: 345678DOO 847879623

8. TOTAL CHARGE: \$260.00

9. AMOUNT PAID: \$260.00

10. BALANCE DUE: \$0.00

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.:

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

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.

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

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

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.