



# BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

## MEMBER REIMBURSEMENT FORM

Use this form to file a claim for any eligible behavioral health expense(s) when your physician or other provider does not file claims. Please PRINT clearly or type.

<b>1. Patient's name:</b> (Only one patient per form)			
Last	First	Middle Initial	
<b>2. Patient's date of birth:</b> mm/dd/yyyy		<b>3. Patient's sex:</b> Male Female	
<b>4. Patient's relationship to subscriber:</b> Self Spouse Child Other (Please explain):			
<b>5. Subscriber information:</b>			
Last		First Middle Initial	
Street		City	State Zip Code
Employer:		Preferred Telephone Number:	
<b>6. Is patient covered under any other benefit plan (including other benefits managed by Behavioral Health Systems)?</b> YES NO			
If the answer is YES, please complete the following:			
Name of subscriber: _____			
Last		First Middle Initial	
Name of carrier: _____		Contract ID Number: _____	
Name and address of employer:			
Name _____			
Street		City	State Zip Code
Is the patient covered under COBRA? YES NO		Policy effective date: mm/dd/yyyy	
Is the patient entitled to Medicare benefits? YES NO		Policy effective date: mm/dd/yyyy	
<b>7. Diagnosis(es):</b>		<b>8. Provider Information:</b>	
_____		Last Name, Credentials First Name	
_____		_____	
_____		Phone Number	
_____		Street City State Zip Code	
<b>INSTRUCTIONS:</b> Attach the original or a copy of the itemized bill or statement from the provider. <b>Make sure the bill contains all the following information:</b>			
<ul style="list-style-type: none"> <li>• Patient's full name</li> <li>• Date(s) of treatment</li> <li>• Description of the treatment ( i.e., therapy, med management)</li> <li>• Diagnosis (type of illness)</li> <li>• Charge for each treatment</li> <li>• Place of treatment (i.e., provider's office, hospital)</li> </ul>			
<b>Please sign:</b>			
I, the undersigned, furnish the above information to permit Behavioral Health Systems to consider this claim for payment, and I certify that the included information is accurate and correct and the expenses were incurred by the above-named patient. I understand that payments will be made to me.			
Signature		Date	
Name (printed)			
<b>MAIL OR FAX THIS FORM WITH THE ITEMIZED BILL OR STATEMENT FROM THE PROVIDER TO:</b>			
<b>Behavioral Health Systems, Inc.</b> P.O. Box 830724 Birmingham, AL 35283-0724 Fax: 205-879-1178 Toll Free: 800-245-1150			