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.

1. Patient's name: (Only one patient per form)

Last First Middle Initial

2. Patient's date of birth: mm/dd/yyyy

3. Patient's sex: ☐ Male ☐ Female

4. Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (Please explain):

5. Subscriber information:

Last First Middle Initial

Street City State Zip Code

Employer: Preferred Telephone Number:

6. Is patient covered under any other benefit plan (including other benefits managed by Behavioral Health Systems)? ☐ 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

7. Diagnosis(es):

_____

_____

_____

_____

8. Provider Information:

Last Name, Credentials First Name

Phone Number Tax ID

Street City State Zip Code

INSTRUCTIONS: Attach the original or a copy of the itemized bill or statement from the provider.
Make sure the bill contains all the following information:

- Patient's full name
- Date(s) of treatment
- Description of the treatment (i.e., therapy, med management)
- Diagnosis (type of illness)
- Charge for each treatment
- Place of treatment (i.e., provider's office, hospital)

Please sign:

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 the subscriber/employee.

Signature Date

Name (printed)

MAIL OR FAX THIS FORM WITH THE ITEMIZED BILL OR STATEMENT FROM THE PROVIDER TO:

Behavioral Health Systems, Inc.
P.O. Box 830724
Birmingham, AL 35283-0724
Fax: 205-879-1178
Toll Free: 800-245-1150