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

beacon health options

Mental Health / Substance Abuse Treatment CLAIM FORM

PART I — TO BE COMPLETED BY EMPLOYEE/PATIENT

1. PATIENT'S NAME (LAST) Smith (FIRST) John (MIDDLE INITIAL) B.

2. PATIENT'S ADDRESS (STREET) 196 Blessing Street (CITY) Smallville (STATE) USA (ZIP CODE) 12345

3. PATIENT'S ID NUMBER (*ON YOUR INSURANCE ID CARD*) 334455667

4. PATIENT'S BIRTHDATE — MONTH 06 | DAY 14 | YEAR 1984

5. PATIENT'S SEX ☒ MALE ☐ FEMALE

6. PATIENT'S RELATIONSHIP TO SUBSCRIBER ☒ SELF ☐ SPOUSE ☐ CHILD

7. EMPLOYEE'S NAME (LAST) Smith (FIRST) John (MIDDLE INITIAL) B.

8. EMPLOYEE'S SOCIAL SECURITY NUMBER 112-34-4567

8a. EMPLOYER NAME / GROUP NUMBER Massachusetts Institute of Technology

OTHER MENTAL HEALTH OR SUBSTANCE ABUSE COVERAGE:

ED BY ANY OTHER GROUP INSURANCE PLAN? ☒ YES ☐ NO

R INSURANCE COMPANY : Mr. Employer, Inc. ID NUMBER: CSDFWER

HER INSURANCE COMPANY 14 Beach Street, Littletown, USA 67890

BLE FOR MEDICARE? ☐ YES ☒ NO

T A E	MONTH	DAY	YEAR	MEDICARE PART B EFFECTIVE DATE	MONTH	D

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:

OVIDER BEEN PAID FOR THESE SERVICES? ☒ YES **(If yes, do not sign 11a)** ☐ NO, **(If no, go to #11A**

SH TO HAVE BENEFITS PAID DIRECTLY TO THE PROVIDER OF SERVICE, PLEASE SIGN BELOW:

N TO PAY PROVIDER. For service described, I hereby authorize payment of benefits, if any, to the named provider. I understa
charges not covered by my contract with Beacon Health Options.

RIBER'S SIGNATURE: DO NOT SIGN if you are paying or have already paid the charges and the reimbursement check should come to YOU DATE

BSCRIBERS'S SIGNATURE

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

SIGNATURE: *John B. Smith* DATE:

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

1. NAME AND LICENSE LEVEL OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY) ***OPTIONAL***
Dr. Stephen Burke, MD

2. NAME AND ADDRESS OF FACILITY WHERE SERVICE RENDERED (IF OTHER THAN HOME OR OFFICE)

3. WAS LABORATORY WOR YOUR OFFICE? ☐ Y
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. F43.11
2. F40.10
3.

5. DID THIS CONDITION RE EMPLOYMENT? ☐ YES ☒ NO
ACCIDENT? ☐ YES ☐ WORK ☐ AUTO

This is called an ICD-10 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
01/05/16	01/05/16	11	90834	Individual Therapy	1	1
01/06/16	01/09/16	11	90834	Individual Therapy	2	3

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

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

Dr. Tom Octavius DATE: 09/25/14

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

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.

UNT NO.
345678SMI

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
BEACON HEALTH OPTIONS ID NO.:

this form or instructions on how to complete, please visit **http://www.valueoptions.com/members.htm**.

Beacon Health Options must have a current W9 on file for the tax ID & address used in boxes 11 & 12. If you have not submitted a W9 to Beacon Health Options in the past, please fax a copy to 866.612.7795.