

Out of Network Claim Form for Members



Employee's Name (First, MI, Last) _____ Date of Birth _____ Sex _____

Employee's Mailing Address _____ Is this a new address? Yes/No

Daytime Phone _____ Alternative Phone _____

Social Security # (UPHS) _____ ID# (University) _____ (Active/Retired/Cobra) Plan Name _____
(Circle)

Circle Your Employer: UPHS University of Pennsylvania

Patient Name (First, MI, Last) _____ Date of Birth _____ Sex _____
(Note: only one patient per form)

Relationship to Employee _____ Social Security # _____ Patient Daytime Phone _____

Provider's Name _____ Daytime Phone _____

Provider's Address _____ Degree/License _____

Description and Dates of Services Received (Please complete all requested information and attach itemized receipts)

Date	Diagnosis ('ICF/32')	CPT Code	Charges \$
_____	_____	_____	_____
_____	_____	_____	_____
_____	Diagnosis (ICD-10)	CPT Code	Charges \$
_____	_____	_____	_____
_____	Diagnosis (ICD-10)	CPT Code	Charges \$
_____	_____	_____	_____
_____	Diagnosis (ICD-10)	CPT Code	Charges \$
_____	_____	_____	_____
_____	Diagnosis (ICD-10)	CPT Code	Charges \$
_____	_____	_____	_____
_____	Diagnosis (ICD-10)	CPT Code	Charges \$
_____	_____	_____	_____
_____	Diagnosis (ICD-10)	CPT Code	Charges \$
_____	_____	_____	_____

Please note that as of 1/1/13 CPT codes have been changed. Some of the deleted CPT codes are (90801, 90802, 90862, 90805, 90806, and 90807 etc....). YOUR PROVIDER MUST USE THE NEW 2013 AMA CPT CODES OR YOUR CLAIMS WILL BE DENIED. Claims submitted for dates of services prior to January 1, 2013 will be accepted under the old CPT codes.

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Both Employee and Patient Must Sign all Claims

A. AUTHORIZATION TO RELEASE INFORMATION - I authorize any health care provider, insurance company, employer, person or organization to release any information regarding the medical, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to Penn Behavioral Health Corporate Services, the plan administrator, or their authorized agents for the purpose of validating and determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.

Patient's (Parent or Guardian) Signature _____ Date _____

Employee's Signature (if different from patient) _____ Date _____

B. CERTIFICATION – I certify that all of the above information is true and correct.

IF YES, Employee's Signature _____ Date _____

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

C. REQUIRED New CPT CODES MUST BE PROVIDED ON THE FORM AND ON THE RECEIPTS –

Effective January 1, 2013 The American Medical Association (AMA) new behavioral health CPT codes issued October 2012 for dates of service on or after January 1, 2013 will go into effect. These changes will impact both payors and service providers. This affects all provider types (psychiatrists, psychologists, clinical social workers, etc.) that provide behavioral health services in all states. Please note claims submitted for payment with the old deleted codes will result in denial and need for resubmission. The new CPT codes are mandatory; noncompliance is a HIPAA violation under the Transaction and Code Set Rule.

NOTE: The processing of claims may take up to 30 days. Some suggestions to ensure that your claims are processed in an efficient and timely manner are:

- (a) For claims with a new provider, please preregister by contacting Penn Behavioral Health Corporate Services at 888-321-5533
- (b) Complete this form accurately with all required information and attach all relevant claims materials to form
- (c) Provide a separate form with separate receipts for each patient receiving treatment (if there are several family members receiving treatment at the same time). **REMEMBER – PROVIDERS MUST USE NEW CODES**

How to File a Claim:

Covered persons are never required to file a claim when covered services are provided by Preferred (In-Network) Providers. When they receive care from a Non-Preferred (Out-of-Network) Provider, they will need to file a claim or have their provider file a claim for the covered participant to receive reimbursement. In some cases, at the discretion of the contract administrator, arrangements may be made to have payments made directly to the provider such as in the case of a Facility Provider or other hospital setting.

To file a claim, the covered person can call Member Services (Access Services Department) at the number listed on the back of their identification card, (1-888-321-5533) and the full process for filing a claim will be described. There are two options:

The individual can complete an Out of Network claim form posted in the **BEHAVIORAL HEALTH BENEFITS** section of the website @ www.pennbehavioralhealth.org (Under **UPHS Benefits** and **University Benefits**) or request that forms be sent to them by Claims Services (Claims Department) by calling (1-888-321-5533)

- (a) The following information is required when completing a claim form:
 - Name of Covered Participant
 - Name of Patient
 - Address
 - Phone Numbers
 - Date of Birth
 - Employee (Primary Covered Member) ID #
 - Plan Name
 - Provider's Name, Address, Phone Number, and Degree/License
 - Description of Dates and Services Rendered
 - Signatures

- (b) Please submit the claim form along with itemized bills or copies of receipts containing:
 - The Non-Preferred (Out-of-Network) Provider's (Qualified Professional or Facility Provider) Name (with degree/license)
 - Tax I.D. number
 - Address
 - Phone number
 - Dates of Service
 - Diagnosis (by listed codes and/or description) and services performed (by codes or rates) with associated itemized charges

The employee or covered individual (or their designated legal guardian/custodian) must complete the claim form and include all required information. Both the employee and covered individual must sign the claim form. Please return the completed form with all itemized bills to:

**Penn Behavioral Health Corporate Services
Claims Administrator**

**3440 Market Street, Suite 450
Philadelphia, PA 19104**

Telephone: 1-888-321-5533, Access Department for Customer Service