Magellan HEALTHCARE SM

P.O. Box 1289 • Maryland Heights, MO 63043

Claim Form
to Pay Insured/Subscriber

Each item on this form needs to be completed.
Instructions for completion are listed on the reverse side.

Please print or type.

1

Insured/Subscriber Name (Last, First, Middle Initial)

Mailing Address

City and State | **ZIP Code**

Insured Employed? ☐ Yes ☐ No ☐ Retired

Date of Retirement: Month Day Year _____/_____/_____

2

Group Number | **Insured/Subscriber Identification Number** (from ID card)

Patient's Full Name (Last, First, Middle)

Patient's Sex | **Patient's Date of Birth** Month Day Year _____/_____/_____

Patient's Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____

3

Type of treatment received:
Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment.

☐ Outpatient
☐ Applied Behavior Analysis
☐ Other _____

4

Diagnosis DSMV or brief description of symptoms:

_____

_____

_____

5

Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? ☐ Yes ☐ No

Insurance Co. _____

Address _____

Employer _____

Insured name _____

Policy # _____

Effective date of coverage Month Day Year _____/_____/_____

Sex of Insured ☐ Male ☐ Female

Date of birth of insured _____/_____/_____

Relationship to patient _____

If the other coverage is primary, attach the other insurance company's Explanation of Benefits.

6

Medicare — Is the patient:

			Month Day Year
a) Entitled to benefits under Medicare insurance (Part A)?	☐ Yes ☐ No	Effective	_____/_____/_____
b) Entitled to benefits under Medicare insurance (Part B)?	☐ Yes ☐ No	Effective	_____/_____/_____
c) Entitled to benefits under Medicare due to a disability?	☐ Yes ☐ No	Effective	_____/_____/_____

Patient's Medicare Identification Number. (From Medicare ID card) _____

7

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any Hospital, Physician, Provider, Insurance Carrier or other entity to give Magellan Healthcare and Blue Cross and Blue Shield of Texas, upon request, any medical information which the Plans in their judgment deem necessary to the adjudication of this claim. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured	**Date**	**Daytime telephone number**

8

Total amount for ALL covered services and supplies received.	**$**

Itemized Bill(s) for covered services and supplies must be attached. ***(See Instructions on reverse side.)***

Magellan HEALTHCARE℠

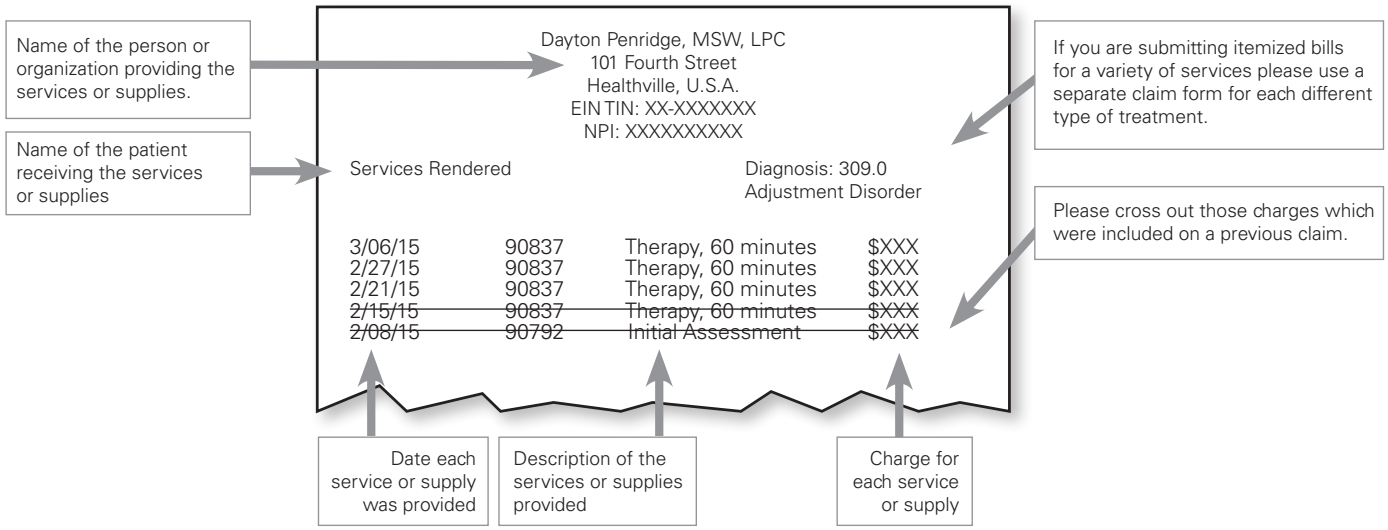
Claim Form
to Pay Insured/Subscriber

INSTRUCTIONS

Important: DO NOT file this form if your Provider of Service is submitting these charges to Magellan Behavioral Health Systems, LLC.

Please complete every item on claim form.

1	Insured/subscriber's name, address and employment status	Please show the insured/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Texas identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured/subscriber's employment status. If retired, give date of retirement.
2	Patient information	Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.
3	Type of treatment received	Check only one treatment type. You may attach multiple itemized statements if they are for one type of treatment per claim form.
4	Provide DSM V diagnosis code	Give diagnosis or a brief description of symptoms.
5	Other insurance	Please check appropriate box. If "yes," complete the required information.
6	Medicare information	Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number. Medicare Enrollees should include a copy(s) of the Medicare Explanation of Benefits Form(s) (EOB) with their itemized statements unless patient is actively employed and requires group coverage to pay primary.
7	Insured's signature, date and daytime telephone number	Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain all the information shown in the following example:
8	**Example of Itemized Bill** — **Please remember to attach the original bill(s) to the claim form and make a copy for your records. Itemized bills cannot be returned.**	



This completed form, together with the itemized bills, should be submitted:

By mail to:
Magellan Behavioral Health Systems, LLC
Attn: Claims
P.O. Box 1289
Maryland Heights, MO 63043

or

By fax to:
(888) 656-4942

Magellan HEALTHCARE SM

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, age or disability.

To receive language or communication assistance free of charge, please call us at 800-442-4093.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Civil Rights Coordinator,
Corporate Compliance Department
6950 Columbia Gateway Drive
Columbia, MD 21046

Phone: 800-424-7721
Fax: 410-953-5207
Email: compliance@magellanhealth.com

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

Magellan HEALTHCARE SM

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-4093.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 800-442-4093.
繁體中文 Chinese	如果您, 或您正在協助的對象 對此有疑問 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 800-442-4093.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-4093.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-442-4093 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 800-442-4093 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 800-442-4093 पर कॉल करें ।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、800-442-4093 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 800-442-4093 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກ້າລັ້ງໄຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍຄວ້ການຊ່ວຍເຫຼືອ ແລະ ຂໍ ມນເປ ນພາສາຂອງທ່ານໄດ້ໂດຍບ ມ ຄ່າໃຊ້ຈ່າຍ. ເພ ອລ ມກ ບນາຍແປພາສາ, ໃຫ້ໂທ ຫາເບ 800-442-4093.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 800-442-4093.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار 800-442-4093 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 800-442-4093.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener avuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-4093.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-442-4093.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 800-442-4093 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-4093.