



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:			
<ul style="list-style-type: none"> • 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			