uprisehealth

BEHAVIORAL HEALTH REIMBURSMENT FORM

PLEASE FILL OUT A SEPARATE FORM FOR EACH PATIENT.

*Use this form to file a claim for any eligible behavioral health expense(s) when your behavioral health provider does not file claims. Please **print clearly with black ink** 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 gender: ☐ Male ☐ Female

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

5. Contract holder information:

Last First Middle Initial

Street City State ZIP Code

Place of Employment Daytime Telephone Number:

6. Is patient covered under any other behavioral health benefit plan (including other benefits managed by Uprise Health)? ☐ YES ☐ NO

If the answer is **YES**, please complete the following:

Name of policy holder: Last First Middle Initial

Name and address of insuring company: Name

Street City State ZIP Code

Is the patient entitled to Medicare benefits?

Part A: ☐ YES ☐ NO *Part B:* ☐ YES ☐ NO

Policy effective date: mm dd yyyy

Medicare Number:

7. Diagnosis(es) (type of illness or injury):

8. Ordering Provider:

Last Name First Name

Phone Number

Street

City State ZIP Code

INSTRUCTIONS: Attach the original or a copy of the bill or statement from the provider and **keep a copy for your records. Make sure the bill contains all the following information:**

Note: The information listed below is usually provided on an itemized bill from the provider.

- The patient's full name
- A diagnosis (type of illness)
- The date of treatment
- The charge for each treatment
- A description of the treatment (i.e. therapy, med management)
- Place of treatment (i.e. provider's office, hospital)

Sign this form:

I, the undersigned, furnished the above information to enable American Behavioral to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above-named patient. **I understand that any payment will be made to me.**

Signature Date

Printed Name

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

PO Box 30018
Laguna Niguel, CA 92607
Fax: 714-556-5430