Out-of-Network Behavioral Health
Claim Form

AmeriBen

Please use a separate claim form for each patient and provider. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing.
SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

SECTION 1: PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth

Does the patient have other health insurance coverage?	Relation to subscriber	Sex
☐ Yes ☐ No	☐ Self ☐ Spouse ☐ Daughter ☐ Son	☐ Male ☐ Female

Name of other health insurance company	Employer Name	Group no.	Policy no.

SECTION 2: SUBSCRIBER INFORMATION (on AmeriBen/Anthem ID card)

Identification no.	Group no.

Last Name	First Name	M.I.

Street Address	City	State	Zip

Home Phone no.	Work Phone no.	Date of Birth (DD/MM/YYYY)

SECTION 3: MEDICAL INFORMATION

BEHAVIORAL HEALTH SERVICES: Use this section to report any COVERED health service that has not already been reported to this Anthem Blue Cross and Blue Shield Plan by the provider of service. **Attach itemized bill or photocopy.** Please be sure that duplicate bills are not submitted.

Where was the service rendered? ☐ Physician Office ☐ Outpatient ☐ Inpatient ☐ Telehealth

Date of Service	Dignosis Code	Procedure Code	Tax ID	Amount
			Total	$0

BILLS MUST BE ITEMIZED.

Cancelled checks, cash register receipts, and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- ✓ Name and address of provider
- ✓ Name of patient
- ✓ Service provided
- ✓ Date of service
- ✓ Amount charged for each service
- ✓ Diagnosis code
- ✓ Procedure code
- ✓ Tax ID

I certify that, to the best of my knowledge, the information on this claim form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature	Printed name	Date (MM/DD/YYYY)
X		

HOW TO USE THIS FORM

If a behavioral health provider opts to bill you for services rendered, rather than submit a claim to the network on your behalf, please use the attached Out of Network Behavioral Health Claim Reimbursement form to notify us.

If you need any assistance completing this form, please contact AmeriBen Customer Care at **888-235-4713.**

SECTION 1: PATIENT INFORMATION

Use this section to identify the patient.

SECTION 2: SUBSCRIBER INFORMATION

Use this section to identify the subscriber. This information may be found on your ID card.

SECTION 3: MEDICAL INFORMATION

Use this section to report any COVERED behavioral health service that has not already been reported to Anthem Blue Cross and Blue Shield by the provider of service. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

The provider's billing office should assist in supplying codes to help complete this section of the reimbursement form:

- Diagnosis code
- Procedure code
- Tax Identification Number

The completed claim form and supporting documentation can be submitted to Ameriben by:

Mail: AmeriBen
ATTN: Client Services,
PO Box 7186
Boise, ID 83707

Fax: 208-955-1415

Upload: Access your member profile at www.MyAmeriBen.com and upload to your forms.

If you need any assistance in completing this form,
please contact AmeriBen Customer Care at 888-235-4713.