Out of Network Medical Claim Form*

*only for Alternative Medicine Claims (Acupuncture, Massage, Rolfing…) and Mental Health Providers approved by NBB.

Fill out the form completely. An itemized receipt must accompany the claim form. The itemized receipt should include the following information:

- Patient Name
- Date of Service
- Provider Name and Address
- Description of service(s) rendered
- Total charges

Save claim form as a PDF attachment and submit with appropriate receipts. Failure to provide complete and accurate information could result in a delay in processing the claim.

You can check the status of your claim via the myAmeriBen portal approximately 30-45 days after the claim submission.

PATIENT INFORMATION

Patient's Name (First, Middle, Last)	Patient's Date of Birth
Patient's Address (Street, City, State, Zip Code)	
Patient's Gender ◯ Male ◯ Female ◯ Prefer Not To Answer	Patient's Relationship to Employee ◯ Self ◯ Spouse ◯ Child ◯ Other_____

SUBSCRIBER / POLICYHOLDER INFORMATION

Subscriber's Name (First, Middle, Last)	Subscriber's ID Number	Subscriber's Date of Birth
Subscriber's Address (Street, City, State, Zip Code)		

SERVICES RENDERED

Date of Service	Diagnosis Code[1]	Procedure Code / Description[2]	Tax ID Number[3]	Paid Amount

[1]Diagnosis code is not required for massage therapy. Enter "preventive" for diagnosis.
[2]Procedure code not required for massage therapy. Enter description of "massage".
[3]Tax ID Number not required for massage therapy. Enter "N/A".

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

Signature X	Printed Name	Date