Mass General Brigham
Health Plan

Behavioral Health Reimbursement

This checklist will guide you through the process of requesting a behavioral health reimbursement.

I have completed and attached the following:

☐ Signed member reimbursement form with all sections clearly completed. This form is on the next page.

☐ For behavioral health claims, an itemized provider bill that includes:

1. Provider information:
   - Provider name
   - Provider address
   - National Provider Identifier and/or Provider Tax Identification Number
2. Patient's name
3. Date(s) of service
4. Itemized charges for each date of service and type of service received
5. Procedure codes (CPT/HCPCS/revenue codes) for all services received
6. Number of units billed for each procedure code (CPT/HCPCS/revenue code)
7. Diagnosis code(s) for services received
8. If the claim is for services received outside of the United States, please include the name of the foreign currency (for example: euros, pesos, British pounds, etc.)

☐ Proof of payment:
   - Credit or debit card statement
   - Financial statement that includes a copy of the front and back of canceled check issued to the provider
   - Receipt of payment by provider for cash payments (all cash payments must include proof of source of funds, such as wire transfer, travelers check receipt, or bank statement)

Mass General Brigham Health Plan may contact providers to validate services rendered and/or payment amounts.

Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer. You don't have to use the form, but it will help us process the information faster.

Questions about this form? Call the customer service number on the back of your member ID card, email **healthplanmedadvcustomerservice@mgb.org**, or visit **Member.MassGeneralBrighamHealthPlan.org** to chat with a customer service professional.

Member Reimbursement Claim Form
for Behavioral Health Services

Mass General Brigham
Health Plan

1. Complete this form and checklist to request reimbursement when a provider bills you directly for a covered service.
2. Requests must be submitted within 12 months of the date of service.
3. Complete one form per family member and one form per claim.
4. Keep a copy of all receipts and documents for your records.

Mass General Brigham Health Plan reserves the right to request further information to support your claims.

A. Patient and Subscriber (Plan Holder) Information

1. Patient Member ID

2. Patient Name
First MI Last

3. Patient Date of Birth
Month Day Year

4. Patient Address

5. Secondary Coverage: Does the patient have other insurance? ☐ Yes ☐ No
Name and ID number of the plan:

6. Was this claim due to an accident? ☐ Yes ☐ No

B. Provider or Hospital Information

7. Provider's Name

8. Contact Person *if available*

9. Provider Phone Number

10. Provider Address

11. Outside the United States
In what country was the patient seen? _____
In what language was the bill written?_____
In what currency was the bill paid? _____

C. Description of Services

12. Type of Service — Behavioral Health

13. Please describe what you were seen for/diagnosis *(e.g., depression, anxiety, etc.).*

14.

Date(s) of service	Description of procedures, services, or supplies provided	Amount paid

Please indicate total amount paid for services — *include total in foreign currency and the U.S. equivalent if necessary* _____

Please mail this form and all documentation to:

Optum
P O Box 30757
Salt Lake City, UT
84130-0757

I hereby apply for benefits and certify that the above information is complete, true, and correct. To all physicians and other behavioral health professionals, hospitals, and other behavioral health care institutions, and to insurers, behavioral health or hospital service and prepaid health plans, employers and group policy holders, contract holders, or benefit plan administrators: You are authorized to provide the plan and any benefit plan administrators from consumer reporting agencies, attorneys, and independent claim administrators acting on the plan's behalf with information concerning behavioral health care, advice, treatment, or supplies provided to the patient and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Form must be signed.
Claim cannot be processed without member's (or authorized representative's) signature.

Member's signature (or authorized representative's) signature Date