Carolina Behavioral Health Alliance, LLC
P.O. Box 571137
Winston-Salem, NC 27157-1137
Phone: 1-800-475-7900 Fax: (336) 499-4006

Health Insurance Claim Form

1. To file a claim for behavioral health services, please fully complete the front of this form.
2. Your psychiatrist or therapist may complete the reverse side, or you may attach an itemized bill that contains dates, billed dollar amounts, procedure codes and diagnosis codes for each service provided. If payment is to be issued to the enrollee, a paid receipt for services must also be submitted.
3. If the patient is covered by Medicare, submit BOTH an itemized bill and a Medicare Explanation of Benefits to speed processing.
4. Send the completed claim form and bills to Carolina Behavioral Health Alliance, LLC at the above address.

GROUP # _____

I. EMPLOYEE DATA

Name (First, Middle & Last)	Gender ❑ Male ❑ Female	Date of Birth	Member ID #

Home Address Street	City	State	Zip Code	Is this a new address? ❑ Yes ❑ No

II. PATIENT DATA

Patient Name (First, Middle & Last)	Gender ❑ Male ❑ Female	Date of Birth	Relationship to Employee: ❑ Self ❑ Spouse ❑ Child ❑ Other

If patient is dependent child over age 18, complete Full-time student information:	School Name	City & State	Date current semester began

Complete the following parental information if the patient is a dependent child:

Are natural parents divorced or separated? ❑ Yes ❑ No	If Yes, who has custody?	Does natural parent WITHOUT custody have financial responsibility for health expense? ☐ Yes ☐ No If Yes, does this natural parent or spouse carry insurance on the child? ☐ Yes ☐ No

Reason for Claim ❑ Illness ❑ Accident	If services were received outside of the service area, please explain why:	❑ Business or vacation travel	❑ Residing out of area	❑ To get medical care

If Accident, please provide date, location and how it happened.	Date	Place	How it happened

Was illness or accident work related? ❑ Yes ☐ No	If Yes, Date of occurrence	Name of Employer	Employer Phone Number

IV. OTHER INSURANCE DATA (must be completed if patient is covered by any other insurance)

Was this patient covered by another group health plan, Medicare, or other government plan at the time charges were incurred? ☐ Yes ☐ No If Yes, Complete the following:

Insured's Name	Insured's ID Number	Name of Employer	Group Number

Name of Other Insurance Company	Address of Other Insurance Company	Phone Number

V. AUTHORIZATION TO RELEASE INFORMATION – CERTIFICATION OF ACCURACY

I authorize all physicians, health professionals, hospitals, clinics and any other medically-related facilities to provide Carolina Behavioral Health Alliance (CBHA) information concerning health care, advice or treatment provided to the patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that CBHA will not release any information obtained by this authorization to any person or organization except reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my claims or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be valid as the original. I agree that this authorization shall be valid for the duration of my claim.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Patient's Signature (Required if patient is 18 years of age or older)	Date

Claimant's Signature (if other than the patient & claiming reimbursement)	Date

If claimant is other than patient or employee, attach a paid receipt for services and specify return/payment address.	Address

Statement from Provider of Service

Items #4 through #8 and #11 below do not need to be filled in if the employee's statement on the reverse side of this form is completed.

HEALTH INSURANCE CLAIM FORM

Please type or print.

PATIENT & EMPLOYEE (SUBSCRIBER) INFORMATION

1. Patient's Name (First, Middle initial, Last Name)	2. Patient's Date of Birth	3. Employee's Name (First, Middle Initial, Last Name)
4. Patient's Address (Street, City, State, ZIP Code) Telephone Number: ( )	5. Patient's Gender ❑ Male ❑ Female 6. Relationship to Employee ❑ Self ❑ Spouse ❑ Child ❑ Other	7. Employee's I.D., Medicare/Medicaid No (include any letters) 8. Employee's Group Number (or Group Name)
9. OTHER HEALTH COVERAGE – Enter name of Planholder or Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. Was condition related to A. Patient's Employment ❑ Yes ❑ No B. An Automobile Accident ❑ Yes ❑ No	11. Employee's Address (Street, City, State, ZIP Code)
Read other side of form before completing & Signing this form. 12. Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. Signed Date		13. Insured's or Authorized Person's Signature: I authorize payment of medical benefits to the undersigned service provider for services described below. Signed

SERVICE PROVIDER INFORMATION

14. DATE OF CURRENT ◄ Illness [first symptom] or Injury [accident]	15. If patient has had same or similar illness give first date:	16. Dates patient unable to work in current occupation From: To:
17. Name of referring physician or other source	17a. I.D. Number of Referring Physician	18. Hospitalization dates related to current services: From: To:
19. Name & Address of facility where services rendered (if other than home or office)		20. Was laboratory work performed outside your office? $ Charges ❑ Yes ❑ No

21. DIAGNOSIS (Relate items 1,2,3 or 4 to procedure in Column D by Diagnosis Code.)

1. _____ . _____ 2. _____ . _____

3. _____ . _____ 4. _____ . _____

22. MEDICAID Resubmission Code Original Ref. Number

23. AUTHORIZATION NUMBER Issued by CBHA

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H CBHA Use Only

25. Federal Tax I.D. Number SSN ☐ EIN ☐	26. Patient's Account Number	27. Accept Assignment? (Government Claims Only) ❑ Yes ❑ No	28. Total Charge	29. Amount Paid	30. Balance Due

31. SIGNATURE OF SERVICE PROVIDER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side apply to this bill and are made part thereof.) Signed Date	32. SERVICE PROVIDER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NO.
NPI #	NPI #
National Provider Identification Number Required	National Provider Identification Number Required

MAIL ALL CLAIMS TO: Carolina Behavioral Health Alliance, LLC, P.O. Box 571137, Winston-Salem, N.C. 27157-1137