MAGELLAN HEALTH SERVICES
STATEMENT OF CLAIMS FOR
BEHAVIORAL HEALTH BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. Complete for all Claims

Employee's Name ____________ _ Male _ Female

Employee's Home Address ____________ Member ID ____________

City, State, Zip Code ____________ Marital Status ____________

Date of Birth (Month, Day, Year) ____________

2. Complete for Dependent Claims Only

Dependent's Name (Spouse/Child) ____________ _ Male _ Female

Relationship to Employee ____________ If Claim for Dependent Child over age 19, indicate:

Date of Birth ____________ _ Full-time Student _ Disabled

Dependent's address, if different from employee ____________ Name of School, if Student ____________

3. Complete for all Claims

Are you, your spouse or dependent(s) entitled to benefits from any other group health insurance?
_ Yes _ No

Name of Other Employer ____________ Member ID ____________

Name and address of the insurance carrier providing these benefits ____________ Policy Number ____________

4. Complete for Accidents Only

Date of Accident: ____________ Work Related: _ Yes _ No

Description of the accident (How, When, Where): ____________

5. Complete for all Claims

I hereby agree to reimburse Magellan Health Services for any overpayment made by the Plan.

I hereby apply for benefits and certify that the above information is complete, true and correct.

To all physicians and other medical professionals, hospitals and other medical care institutions and to insurers, medical or hospital services and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators, with information concerning medical care, advice, treatment or supplies provided 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. You are also hereby authorized to release to regulatory and law enforcement agencies of the State of Illinois certain claims information necessary for investigations and prosecution of fraud and abuse. 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.

Claim cannot be processed without employee's signature

____________ ____________
Employee's Signature Date Dependent's Signature (if not Minor) Date

6. Complete only if you want payment to go directly to Provider

Authorization to Pay Benefits: I hereby authorize payment directly to the provider of service for the enclosed expenses as provided under the Plan. I understand I am financially responsible for charges not covered by this authorization.

Employee's Signature: ____________ Date: ____________

Claims address: Magellan Health Services
P.O. Box 2216, Maryland Heights, MO 63043

Telephone: (800) 513-2611
TTY: (800) 526-0844

HOW TO SUBMIT A CLAIM

1. Fill out every section of the claim form completely.

2. Include your Member ID.

3. Attach only original itemized claims (not copies) with the out-of-network claim form.

   Hospital Charges: Attach a fully completed UB-92 CMS-1450, or CMS-1500 form.

   Other Professional Charges: Attach a fully completed CMS-1500 form.

4. The provider must show their level of licensure (i.e. MD, PhD, LCSW, LMFT, or LCPC) on the CMS-1500.

5. If Quality Care Health Plan (QCHP), Local Care Health Plan (LCHP), Teachers' Choice Health Plan (TCHP), or College Choice Health Plan (CCHP) is primary, you must attach the original UB-92 CMS-1450 or CMS-1500 form. If the patient is covered by Medicare or another group insurance plan which is primary, the claims must be filed under that plan first. A claim can then be filed under QCHP, LCHP, TCHP, or CCHP by attaching a copy of the other plan's Explanation of Benefit payments along with a copy of the UB-92 CMS-1450 or CMS-1500 form.

6. Then send to:

   Magellan Health Services
   P.O. Box 2216
   Maryland Heights, MO 63043

8. If you have any questions, please call Magellan Health Services at (800) 513-2611.