

**INSTRUCTIONS**

Use of Claim Forms:

1. A completed claim form is required for each bill submitted.
2. The supplier should complete Part II OR furnish an itemized bill.
3. For hospital charges, include a copy of the itemized hospital bill.

Mail completed form and attachments to:

Value Behavioral Health  
P. O. Box 140489  
Irving, TX 75014

How to submit Itemized Bills:

1. All bills should include the employee's and patient's name, date and type of service, and the charge for each. Provider's bills should also include the type of treatment and diagnosis. **Cancelled checks and receipts are not acceptable.**
2. Please be sure you have provided the **employee's Social Security Number.**

For Claim Assistance or Information:

Additional claim forms may be obtained from VBH. For claim inquiries only, call VBH at 1-800-684-4293.

<b>PART I TO BE COMPLETED BY EMPLOYEE</b>				
1. EMPLOYEE'S NAME (LAST)		(FIRST)		(MIDDLE INITIAL)
2. EMPLOYEE'S ADDRESS (STREET)		(CITY)	(STATE)	(ZIP CODE)
3. EMPLOYEE'S SOCIAL SECURITY NUMBER			4. EMPLOYEE'S PHONE NUMBER	
PATIENT INFORMATION				
5. PATIENT'S NAME (LAST)		(FIRST)		(MIDDLE INITIAL)
6. PATIENT'S BIRTHDATE MONTH   DAY   YEAR	7. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	8. PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE	9. DIAGNOSIS OR NATURE OF ILLNESS	

**OTHER COVERAGE**

10. IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES	NAME OF INSURANCE COMPANY			POLICY NUMBER
	ADDRESS OF INSURANCE COMPANY			PATIENT'S SOCIAL SECURITY NUMBER
11. IS THE PATIENT ELIGIBLE FOR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES	MEDICARE PART A EFFECTIVE DATE		MONTH   DAY   YEAR	MEDICARE PART B EFFECTIVE DATE
			MONTH   DAY   YEAR	
<b>If the patient is covered under any other insurance, attach a copy of any bill(s) submitted to the carrier and the explanation of Benefits form.</b>				
12. HAS THE PROVIDER BEEN PAID? <input type="checkbox"/> YES <input type="checkbox"/> NO				
13. IF CLAIM FOR DEPENDENT CHILD AGE 19 OR OVER, IS CHILD A FULL-TIME STUDENT?				
SCHOOL NAME: _____				
IS CHILD EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO _____				

**ASSIGNMENT OF BENEFITS:**

IF YOU WISH TO HAVE BENEFITS PAID DIRECTLY TO THE PROVIDER OF SERVICE, PLEASE SIGN BELOW:

AUTHORIZATION TO PAY PROVIDER. For service described, I hereby authorize payment of benefits, if any, to the named provider. I understand I am financially responsible for the charges not covered by this authorization.

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**EMPLOYEE'S SIGNATURE:**

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named, and hereby authorize any insurance company, organization, employer or provider of service to release any information with respect to this claim form.

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_