Harvard Pilgrim HealthCare

United Behavioral Health Claim Form

UNITED BEHAVIORAL HEALTH

INSTRUCTIONS FOR SUBMITTING CLAIMS

1. Use a separate form for each family member, each different provider of service, and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
   FULLY ITEMIZED BILLS **MUST** CONTAIN THE FOLLOWING INFORMATION:
   Date(s) of service, diagnosis(es), type(s) of service, procedure code(s), charge for each service, provider name and type of license, address, phone number, provider tax ID number and provider NPI number (both are necessary).
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs United Behavioral Health to pay the provider. If the patient chooses not to sign this authorization, benefits will be paid to patient.
4. Please send claim to United Behavioral Health, P.O. Box 30602, Salt Lake City, UT 84130.

EMPLOYEE INFORMATION (Complete For All Claims)

EMPLOYER NAME		GROUP NUMBER		
EMPLOYEE'S NAME *(LAST, FIRST, M.I.)*		EMPLOYEE'S STREET ADDRESS		
EMPLOYEE'S DATE OF BIRTH	EMPLOYEE'S SSN	CITY	STATE	ZIP CODE
THIS CLAIM IS FOR ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER – ***Please specify***				

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST M.I.)	PATIENT'S DATE OF BIRTH	PATIENT'S ID#
PATIENT IS RETIRED (Check if applicable) ☐FEMALE ☐ MARRIED ☐DISABLED ☐ ☐ MALE ☐ SINGLE ☐ON MEDICARE ☐ STUDENT	If patient is disabled, give date of disability	
Patient was Treated for: ☐ ILLNESS ☐PREGNANCY ☐INJURY AT WORK ☐ACCIDENTAL INJURY ☐OTHER – *Please Specify*		
If accident involved, give date, how and where accident occurred		

Does patient have other health coverage? ☐ YES ☐ NO	IF YES, NAME OF INSURANCE COMPANY	GROUP NUMBER	POLICY NUMBER
ADDRESS OF INSURANCE COMPANY			

NAME OF POLICY HOLDER	SEX OF POLICY HOLDER ☐ MALE ☐ FEMALE	POLICY HOLDER'S DATE OF BIRTH
NAME OF POLICY HOLDER'S EMPLOYER	POLICY HOLDER'S EMPLOYER'S ADDRESS	

AUTHORIZATIONS

RELEASE OF INFORMATION

I hereby authorize the release of any medical information necessary to process this claim.

_____
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

Sign here ONLY if you are approving payment to be made directly to the provider; LEAVE BLANK if you wish to be reimbursed.
I hereby authorize benefits to be paid directly to the provider of service for this claim.

_____
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
DATE

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE
TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

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PHYSICIAN OR SUPPLIER INFORMATION

Date of Illness (first symptom) OR Injury (accident) OR pregnancy (LMP)	Date you were first consulted for this condition	If patient has had same or similar injury, give dates	If emergency, Check here ☐
Date patient able to return to work	Dates of total disability FROM / THROUGH	Dates of partial disability FROM / THROUGH	
Name of referring physician or other source (e.g., Public Health Agency)		For services related to hospitalization, give dates ADMITTED / DISCHARGED	
Name and address of facility where services were rendered (if other than home or office)		Was laboratory work performed outside your office? ☐ YES ☐ NO	

Diagnosis or nature of illness or injury
1.
2.
3.
4.

Please relate diagnosis to procedure using reference numbers (1, 2, 3, etc.)

FAMILY PLANNING ☐ YES ☐ NO

Prior Authorization # (if applicable)

Date of Service	Place of Service**	Procedure Code	Fully describe procedures, medical services, or supplies for each date (explain unusual services or circumstances)	Diagnosis Code	Charges	Days Or Units	TDS	For UBH use only

Patient's Account #	Total Charge	Amt Paid	Balance Due

Provider's Name and License Type	Provider's Address
Provider's Phone #	Provider's Tax ID # and NPI # (both are required)

** 21 INPATIENT HOSPITAL; 22 OUTPATIENT HOSPITAL; 11 DOCTOR'S OFFICE; 12 PATIENT'S HOME; 52 DAY CARE FACILITY; 52 NIGHT CARE FACILITY; 32 NURSING HOME; 31 SKILLED NURSING FACILITY; 41 AMBULANCE; 99 OTHER LOCATIONS; 81 INDEPENDENT LABORATORY; 99 OTHER MEDICAL FACILITY

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND PAYMENT IS THEREFORE DUE.

Signature of Provider (including degree or credentials) Date

MAIL COMPLETED CLAIM FORM TO:

United Behavioral Health
P.O. Box 30602
Salt Lake City, UT 84130
1-888-777-4742

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم أللُغةِ **ألعربية** ، خَدَمات ألمُساعَدة أللُغَوية مُتَوفرة لك مَجاناً. **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.