

PacifiCare Behavioral Health Claim Form

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 of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone #, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If you choose not to sign this authorization, benefits will be paid to you.
4. Please send claims to PacifiCare: P.O. Box 31053, Laguna Hills, CA 92654--31053

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 <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER – <i>Please specify</i>				

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST M.I.)		PATIENT'S DATE OF BIRTH	PACIFICARE ID#	
PATIENT IS <input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED (Check if applicable) <input type="checkbox"/> MALE <input type="checkbox"/> SINGLE <input type="checkbox"/> ON MEDICARE <input type="checkbox"/> STUDENT		If patient is disabled, give date of disability		
Patient was Treated for: <input type="checkbox"/> ILLNESS <input type="checkbox"/> PREGNANCY <input type="checkbox"/> INJURY AT WORK <input type="checkbox"/> ACCIDENTAL INJURY <input type="checkbox"/> OTHER – <i>Please Specify</i> If accident involved, give date, how and where accident occurred				
Does patient have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF INSURANCE COMPANY	GROUP NUMBER	POLICY NUMBER	
ADDRESS OF INSURANCE COMPANY				
NAME OF POLICY HOLDER	SEX OF POLICY HOLDER <input type="checkbox"/> MALE <input type="checkbox"/> 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 I hereby authorize benefits to be paid directly to the provider of service for this claim. _____ PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE
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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 <input type="checkbox"/>		
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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Diagnosis or nature of illness or injury 1. _____ 2. _____ 3. _____ 4. _____					FAMILY PLANNING <input type="checkbox"/> YES <input type="checkbox"/> NO Prior Authorization # (if applicable) 				
Please relate diagnosis to procedure using reference numbers (1, 2, 3, etc.)									
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 PacifiCare use only	
Patient's Account #					Total Charge		Amt Paid		Balance Due
Provider's Name				Provider's Address					
Provider's Phone #				Provider's Tax ID #					
21 (H) INPATIENT HOSPITAL		12 (H) PATIENT'S HOME		32 (NH) NURSING HOME		99 (OL) OTHER LOCATIONS			
22 (OH) OUTPATIENT HOSPITAL		52 (PSY) DAY CARE FACILITY		31 (SNF) SKILLED NURSING FACILITY		81 (IL) INDEPENDENT LABORATORY			
11 (O) DOCTOR'S OFFICE		52 (PSY) NIGHT CARE FACILITY		41 (AMB) AMBULANCE		99 (OMF) 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:

**PacifiCare Behavioral Health
P.O. Box 31053
Laguna Hills, CA 92654-31053**