Instructions on what and how to file an out-of-network claim for behavioral health services:

This claim form should be submitted when a patient receives services from an out-of-network provider who requests the patient submit reimbursement to their own insurance company.

1. Please include with the completed claim form all itemized statements/invoices provided by the provider. Each statement/invoice should include the following information:

    - Employee ID number
    - Policy holder name
    - Legal name of patient – must match name on file with employer
    - Date of birth of patient
    - Patient address – must match address on file with employer
    - Date of service
    - Type of service rendered - CPT code, Revenue code or verbal description
    - Diagnosis - ICD-10 code
    - Amount of charge – for each CPT code billed
    - Name of provider with provider's degree, address and phone number.
    - Provider's tax identification number
    - Provider's NPI identification number
    - To whom should reimbursement be sent (member or provider)

2. If multiple family members are receiving services, please complete a separate claim form for each person.

3. Review the claim form and statements/invoices for accuracy prior to mailing. This will avoid any unnecessary delays in processing of claims. Keep a copy of the claim form and statements/invoices for your records.

4. Any questions regarding the completion of this form or what is needed on statements/invoices, please contact Accolade at 1-888-560-0902.

5. Mail claim form and statements/invoices to:

    Magellan Health Services
    Attn: Lowe's Claims
    PO Box 1516
    Maryland Heights, MO 63043

Out of Network Behavioral Health Claim Form

Section I Patient Information			
Patients Name	Birth Date (MM/DD/YY)	Sex (circle one) Male or Female	
Street Address	City/State	Zip	
Policyholder Name		**Employee ID Number (or PERN/SSO)**	
Section II Other Insurance Information			
Policyholder Name	**Birth Date**	**Employment Status of Policyholder** **Active Disabled Retired** **(date)**	
Relationship to Patient	**Other Insurance Carrier**	**Other Insurance ID #**	**Other Insurance Effective Date**

Check one ☐ **Pay provider** **OR** ☐ **Pay subscriber**

Complete the information below if the patient is covered by Medicare

Medicare Health Insurance Claim Number Part A Part B Effective Date

AUTHORIZATION

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. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to the benefit administrator all medical or any other information needed for the processing of this claim. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Signature_____Date_____Phone # _____