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(s) of service, diagnosis(es), type(s) of service, procedure code(s), charge for each service, provider name, address, phone number, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If the patient/patient's representative chooses not to sign this authorization, benefits will be paid to patient.
4. Please send claim to PacifiCare Behavioral Health, 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 ☐ 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 ☐FEMALE ☐ MARRIED ☐DISABLED ☐ RETIRED
(Check if applicable) ☐ 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
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 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 INPATIENT HOSPITAL 12 PATIENT'S HOME 32 NURSING HOME 99 OTHER LOCATIONS
22 OUTPATIENT HOSPITAL 52 DAY CARE FACILITY 31 SKILLED NURSING FACILITY 81 INDEPENDENT LABORATORY
11 DOCTOR'S OFFICE 52 NIGHT CARE FACILITY 41 AMBULANCE 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:

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