Claims Information Form

MAIL CLAIMS TO: OPTIMA HEALTH
ATTN: BEHAVIORAL CLAIMS
P.O. Box 1440
Troy, MI 48099-1440

1. Receiving services from an in-network MH/SA provider:
As long as you receive services from MH/SA providers who participate in the Plans' network, he or she will submit claims on your behalf.

2. Receiving services from an out-of-network MH/SA provider:
a) If you received MH/SA services from an out-of-network provider, you will need to file the claim yourself.
b) If you have prepaid for services and wish to receive a reimbursement, please read the instructions below. Please be advised that reimbursement will be made payable to the main policyholder.

3. What to include in your claim:
Whether you or your doctor submits your claim, the following information is needed in order to quickly process your claim. The payment may delay if any of this information is missing. A form is included for your convenience.

• Patient's name and member ID number	• Provider charges for the procedure(s)
• Patient's date of birth	• Provider Tax ID number
• Policyholder's name	• Provider name
• Patient's address	• Provider address where services were rendered
• Patient's phone number	• Provider phone number with area code
• Diagnosis	• Provider licensure (M.D., Ph.D.)
• Date(s) of service	• Statement showing patient has paid in full for services and is entitled to a reimbursement
• Services provided	

If you or your provider has any questions about MH/SA claims submissions, please do not hesitate to call us at 1-800-648-8420. We look forward to assisting you in any way we can.

Last Updated: 11/30/2017

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<table>
<tr><td colspan="4">PATIENT INFORMATION</td></tr>
<tr><td colspan="2">Patient’s Name</td><td>Member ID</td><td>Patient’s Date of Birth</td></tr>
<tr><td colspan="3">Patient’s Address</td><td>Patient’s Phone Number
(   )   -</td></tr>
<tr><td colspan="4">Policy Holder’s Name</td></tr>
<tr><td colspan="4">PROVIDER INFORMATION</td></tr>
<tr><td>Provider Name</td><td>Licensure</td><td>Provider Number Tax ID</td><td>Provider Phone Number</td></tr>
<tr><td colspan="3">Address of Services Rendered</td><td>Date(s) of Service</td></tr>
<tr><td colspan="4">Procedure Code(s)</td></tr>
<tr><td colspan="2">Diagnosis Code(s)</td><td colspan="2">Provider Charges for this Procedure</td></tr>
<tr><td colspan="4">Statement showing patient has paid in full for the services and is entitled to a reimbursement</td></tr>
</table>

Please provide a statement showing the patient has paid in full for services and is entitled to a reimbursement.

Last Updated: 11/30/2017