Sentara Health Plans

Behavioral Health Claims Information Form

Mail claims to:
Sentara Health Plans
Attn: Behavioral Claims
PO Box 8204
Kinsington, NY 12402-8204

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, the provider 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 can file the claim yourself or the non-participating providers can submit claims for a member.
   - **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 provider 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	• Date(s) of service
• Member ID number	• Provider address where services were rendered
• Patient's date of birth	
• Patient's address	• Place of service code
• Patient's phone number	• Procedure code(s)
• Policyholder's name	• CPT/HCPC code(s)
• Provider name	• Diagnosis
• Provider licensure (M.D., Ph.D.)	• Provider charges for the procedure(s)
• Provider Tax ID number	• Statement showing patient has paid in full for services and is entitled to a reimbursement
• Provider NPI number	
• Provider phone number with area code	

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.

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<table>
<tr><th colspan="4">PATIENT INFORMATION</th></tr>
<tr><td>Patient’s Name</td><td colspan="2">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">Policyholder’s name</td></tr>
<tr><th colspan="4">PROVIDER INFORMATION</th></tr>
<tr><td>Provider Name</td><td>Licensure</td><td>Provider Tax ID</td><td>Provider NPI #</td></tr>
<tr><td colspan="2">Provider Phone Number</td><td colspan="2">Date(s) of Service</td></tr>
<tr><td colspan="3">Address of Services Rendered</td><td>Place of Service Code</td></tr>
<tr><td colspan="2">Procedure Code(s)</td><td colspan="2">CPT/HCPC Codes</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 the 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.