

## Behavioral Health Claims Information Form

### Mail claims to:

Sentara Health Plans  
Attn: Behavioral Claims  
PO Box 8204  
Kingston, 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	• Place of service code
• Patient's address	• Procedure code(s)
• Patient's phone number	• CPT/HCPC code(s)
• Policyholder's name	• Diagnosis
• Provider name	• Provider charges for the procedure(s)
• Provider licensure (M.D., Ph.D.)	• Statement showing patient has paid in full for services and is entitled to a reimbursement
• Provider Tax ID number	
• 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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<b>PATIENT INFORMATION</b>			
Patient's Name		Member ID	Patient's Date of Birth
Patient's Address			Patient's Phone Number
Policyholder's name			
<b>PROVIDER INFORMATION</b>			
Provider Name	Licensure	Provider Tax ID	Provider NPI #
Provider Phone Number		Date(s) of Service	
Address of Services Rendered			Place of Service Code
Procedure Code(s)		CPT/HCPC Codes	
Diagnosis Code(s)		Provider Charges for this Procedure	
Statement showing the patient has paid in full for the services and is entitled to a reimbursement:			

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