

Integrated Behavioral Health Mental Health Claim Form



Date	Employee Name	Employee Soc. Sec. Number		
Employee Mailing Address		City	State	Zip Code
Home Telephone Number	Patient's Name	Relationship to Patient		

If your child/dependent is 19 years of age or older, please state the name of the school where your child is currently enrolled. (Proof of student status must be submitted once every twelve months):

Are benefits available from other coverage? Yes No

If yes, Insured's Name: _____ Group: _____ ID#: _____

Carrier's Name: _____

Carrier's Address: _____

Do you wish benefits to be paid directly to the provider? Yes No

Your Signature

Print Name

Date

Note: Unsigned claims cannot be processed.

INSTRUCTIONS FOR SUBMITTING CLAIMS

You do not need to submit this claim form if services were provided by an IBH Network provider.

Attach itemized bill to this claim form. The bill must include CPT (service code), DSM IV (diagnosis code), charged amount, length of session, provider tax identification, all other diagnoses, and signature of the provider of service.

This mental health claim form must be signed by the insured; claims cannot be processed without a signature.

Mail claim to:

**Integrated Behavioral Health
Attn: Claims
P.O. Box 30018
Laguna Niguel, CA 92607-0018**

**For questions, problems or for
prior authorization, call IBH at:**

1-800-395-1616