



## **Filing Claims for Behavioral Health Services (For Members)**

### **How to File a Claim:**

Covered Participants are never required to file a claim when Covered Services are provided by Preferred (In-Network) Providers. When they receive care from a Non-Preferred (Out-of-Network) Qualified Provider, they will need to file a claim or have their provider file a claim for the covered participant to receive reimbursement. In some cases, at the discretion of the Carrier, arrangements may be made to have payments made directly to the provider such as in the case of a facility or other hospital setting.

To file a claim, the Covered Participant can call Member Services (Access Services Department) at the number listed on the back of their Identification Card, (1-888-321-4433) and the full process for filing a claim will be described. There are two options:

- a. The individual can fill out a claim form posted in the member section of the [www.pennbehavioralhealth.org](http://www.pennbehavioralhealth.org) or sent to them by Claims Services (Claims Department) by calling (1-888-321-4433) or
- b. By simply sending in the following information:
  - Name of Covered Participant,
  - Name of Patient,
  - Address,
  - Phone Numbers,
  - Date of Birth,
  - Employee (Primary Covered Member) ID #, and
  - Plan Name

along with their itemized bills containing:

- The Non-Preferred (Out-of-Network) Provider's (Qualified Professional or Facility Provider) Name (with degree/license),
- Tax I.D. number
- Address,
- Phone number,
- Dates of Service, and
- Diagnosis (by listed codes and/or description) and services performed (by codes or rates) with associated itemized charges.

The member (or their designated legal guardian/custodian) must fill out the claim form or include the above pertinent information and return it with any itemized bills to:

PENN Behavioral Health  
Claims Department  
3535 Market Street, 4<sup>th</sup> Floor  
Philadelphia, PA 19104



Please submit claims no later than 90 days after the completion of the Covered Services. The claim should include the date and information required by the Carrier to determine benefits. An expense will be considered “incurred” on the date the service was rendered.

If it is not possible to file the claim within the 90-day period, the benefits will not be reduced, but in no event will the Plan be required to accept the claim more than one (1) year after the end of the Benefit Period in which the Covered Services are rendered. This period will not apply when the person is not legally capable of submitting the claim.

**When Claims Should Be Filed:**

Members are encouraged to file claims with the Claims Department within the 90 days of the date charges for the services were incurred. Benefits are based on the Plan’s provisions at the time the charges were incurred.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If a Covered Person has any questions regarding this procedure, they can contact the PENN Behavioral Health at 1-888-321-4433.