



**Claims Information Form**

**MAIL CLAIMS TO:** OPTIMA HEALTH  
ATTN: BEHAVIORAL CLAIMS  
4417 CORPORATION LANE  
VIRGINIA BEACH, VA 23462

**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.

<ul style="list-style-type: none"><li>• Patient's name and member ID number</li><li>• Patient's date of birth</li><li>• Policyholder's name</li><li>• Patient's address</li><li>• Patient's phone number</li><li>• Diagnosis</li><li>• Date(s) of service</li><li>• Services provided</li></ul>	<ul style="list-style-type: none"><li>• Provider charges for the procedure(s)</li><li>• Provider Tax ID number</li><li>• Provider name</li><li>• Provider address where services were rendered</li><li>• Provider phone number with area code</li><li>• Provider licensure (M.D., Ph.D.)</li><li>• Statement showing patient has paid in full for services and is entitled to a reimbursement</li></ul>
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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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PATIENT INFORMATION			
Patient's Name		Member ID Number	Patient's Date of Birth
Patient's Address			Patient's Phone number (    )    -
Policy Holder's Name			
PROVIDER INFORMATION			
Provider Name	Licensure	Provider Tax ID Number	Provider Phone Number (    )    -
Address of Services Rendered			Date(s) of Service
Procedure Code(s)			
Diagnosis Code(s)		Provider Charges for this Procedure(s)	
Statement showing patient has paid in full for services and is entitled to a reimbursement			