valueHealth Benefit Administrators

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Non-Network Claim Transmittal Form

Instructions

1. This form is used when the non-network provider does not file an insurance claim on behalf of the patient. Network providers must file claims in accordance with the instructions on the patient's health plan identification card.
2. Complete all sections.
3. **Attach an itemized bill from the non-network provider of service which includes:**
   - Provider's Name, address, and taxpayer identification number
   - Name of patient
   - Diagnosis Code and Procedure Code
   - Date of Service
   - Charge Amount

You may have to contact the provider of service to obtain specific information.

PRIMARY PARTICIPANT INFORMATION		
Employer's Name	Group #	Member ID #
First Name, MI, Last Name		Date of Birth
Home Address	City	ST Zip

PATIENT INFORMATION		
First Name, MI, Last Name	Date of Birth	Relationship to Primary Participant
Patient Address		
Nature of illness or condition (diagnosis code(s))		
Type of service received (procedure code(s))		
Name, Address & Phone No. & Tax ID of Treating Physician		

INJURY INFORMATION	
Was the illness or condition the result of an injury? ☐ Yes ☐ No	If the result of an injury, on what date did the injury occur?
Briefly describe how the injury occurred	

OTHER INSURANCE INFORMATION		
Does the patient have any other plan or policy that covers medical, dental, vision or prescription benefits? ☐ Yes ☐ No Identify the type of benefits for which the patient has other coverage. ☐ Medical ☐ Dental ☐ Vision ☐ Prescription		
Identify the Type of plan that covers the patient ☐ Group Health Plan ☐ Medicare ☐ Medicaid ☐ Individual Policy ☐ Other ____________		
Group #	Member/Contract/Policy #	Name of Primary Insured
Name, Address & Phone No. of other insurance company		

SIGNATURE	
Patient's Signature (Parent if Minor, or Authorized Representative) **X**	Date