QUEST
BEHAVIORAL HEALTH

Out-of-Network Claim Form

Quest requires the completion of this form to ensure correct accumulation of your deductibles and out-of-pocket maximums. All claims submitted by members will be paid directly to the subscriber. Out-of-network providers may balance bill you for amounts in excess of the Quest Usual & Customary Rates. If you are owed any reimbursement after Quest payment has been applied, you should seek reimbursement directly from the provider.

Instructions for Filing a Claim

1. This form only needs to be completed if the provider is not submitting the claim on your behalf. Out-of-network providers can submit the claim if they are able and willing. Claims should be mailed to Quest Behavioral Health, PO Box 1032, York, PA 17405. Claims can also be faxed to 717-851-1414 or sent via secure email to claims@questbh.com.
2. To consider your claim for payment, Quest must receive the claim within one (1) year from the date you received the service. Claims received after one year from date of service will be denied.
3. Use a separate claim form for each provider and each member of the family. A new form may be obtained via the Quest website at www.questbh.com/employees-families/my-mental-health-substance-abuse-benefits/OON-claim-form.
4. You must submit an itemized bill from the service provider for your claim to be processed. Receipts, balance due statements, and cancelled checks are not acceptable replacements for the itemized bill.
5. Itemized bills must include:
   - Subscriber name
   - Patient Name
   - Type of Service & Procedure Code
   - Provider Name & License
   - Provider Address
   - Provider Tax ID Number
   - Date of Service (mm/dd/yyyy)
   - Diagnosis Code (ICD-10 format)
   - Charge for service
6. Quest reserves the right to request additional documentation, such as medical records, prior to processing your claim.
7. We suggest you make a copy of your bill(s) and completed claim form for your records.

Subscriber Information				
Last Name:		First Name:		MI:
Sex:	Date of Birth: / /	Phone Number:		
Mailing Address:		City:	State:	Zip:
Is this a new address? ☐ Yes ☐ No		Relationship to patient:		
Patient Information - Complete only if patient is other than subscriber				
Last Name:		First Name:		MI:
Sex:	Date of Birth: / /	Phone Number:		
Mailing Address:		City:	State:	Zip:
Other Coverage Information – Complete only if patient had other coverage at time of treatment				
Does this patient have other coverage in effect? ☐ Yes ☐ No				
Spouse employed? ☐ Yes ☐ No		If no, has spouse been employed within last 12 months? ☐ Yes ☐ No		
Spouse Last Name:		Spouse First Name:		MI:
Spouse Date of Birth: / /		Insurance Company:		
Effective Date of Coverage: / /		Policy Number:		
Is the patient covered by Medicare? ☐ Yes ☐ No		Is the patient covered by Medical Assistance? ☐ Yes ☐ No		
If you answered yes to any of the above, and the other insurer is primary, please include a copy of the Explanation of Benefits (EOB) with this form and the itemized bill(s).				
Certification				
Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any information known to be false; or (2) conceals for the purpose of misleading, information concerning any material fact, thereto commits a fraudulent insurance act, which is a crime. By signing below, I certify that the information supplied is true and correct:				
Authorized signature:			Date: / /	
Note: The information provided on this form may be disclosed to other persons or entities, including my Health Plan, for the purpose of processing this claim and performing health plan administration.				