



Billing for Professional and Facility/Program Services

For answers to questions about Billing for Professional and Facility/Program Services, call the Claims Department Line, 303-368-8201.

Helpful Tips for Getting Your Mental Health Claim Paid

1. Check the validity of the authorization. Based on medical necessity, authorizations specify the treatment code, payment rate, type of service, number of sessions or units of care to be held within a certain time period. Make sure that the treatment codes, date(s) of service and sessions or units of care being billed fall within the requirements of the authorization. Refer to Billing for Services (website) for a sample Referral Authorization Letter.
2. Verify the authorized provider. The provider named on the claim form must match the provider specified on the authorization. All billed services must have been provided personally by the authorized provider.
3. Verify eligibility. If a member becomes ineligible for care before the number of sessions or units of care have been exhausted or the authorization time period has expired, the authorization will be invalid for the dates of service that fall in those time frames. You can verify eligibility by examining the member's Medicaid card or by calling BHI at (720) 490-4400.
4. Use the correct claim form. Behavioral Healthcare, Inc. requires that outpatient providers file their claims on a CMS-1500 form. Inpatient facilities are required to use the UB04/CMS 1450 form.
5. Sign the claim form. Claim forms must indicate the name of the provider actually rendering the service and must be signed by the individual providing care or his/her designee (or facsimile signature).
6. Submit claim forms to the primary insurance company first. If *Medicaid* is not the member's primary insurance plan, the claim must be submitted to the primary insurance company first. The notification of the decision from that insurance company must be attached to the claim form that is submitted to Behavioral HealthCare, Inc. By Federal Law, Medicaid is always the payor of last resort.
7. All claim payments are contingent upon the receipt of a fully completed Colorado Consumer Assessment Record (CCAR), at the time of admission to treatment, discharge and annually if indicated.