Holman Professional Counseling Centers

Managed Behavioral Health Care Services

Dear Valued Client,

This letter is not a guarantee of payment. Although your plan has an out of network benefit, eligibility and confirmation of plan benefits must first be verified. Once verification is established, the following steps must be followed in order for you or your provider to receive reimbursement. If you submitted your claim to your medical provider in error, please submit a copy of your Explanation of Benefits showing your claim was denied.

In order to receive reimbursement, please:

1. Complete the enclosed form, sign it, and have your provider complete their portion. The provider must also sign all billing invoices and/or receipts.

2. **All claims must be submitted within 90 days from date of service**. Return the Request for Out-of-Plan Benefits Reimbursement form with a signed itemized statement and, if you submitted your Behavioral Health claim to the medical plan, include a copy of the claim denial to:

   Holman Professional Counseling Centers,
   9451 Corbin Avenue, Suite 100,
   Northridge, CA 91324.

If you have further questions or need assistance, please feel free to call the Out of Plan Desk at (800) 321-2843.

Sincerely,

Out of Plan Coordinator

The Holman Group
Managed Behavioral Health Care Services

Request for Out-of-Plan Benefit Reimbursement

Please review criteria for available benefits

Employee / Member Information

Name: Last First MI Date of Birth Social Security Number

Home Address City State Zip Code

Employer Home Phone Cell Phone

Client Information

Name: Last First MI Date of Birth Social Security Number

Home Address City State Zip Code

☐ Male Relationship to Insured Home Phone Cell Phone

☐ Female ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Authorization is hereby given to provider to release to HPCC any information which they deem necessary to evaluate this request. In addition, I authorize HPCC to release information to the below named provider/facility as necessary to facilitate treatment.

Signature of Patient, Parent or Guardian Date

☐ I authorize The Holman Group to pay the below named provider directly for services received. (Assignment of Benefits)

Signature of Patient, Parent or Guardian Date

Mental Health Provider Information

Provider Name Degree Provider Social Security Number/Tax ID No.

Mailing Address City State Zip Code

Business Telephone License Number Fee

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Please return completed form to the address below
Attn: Out-of-Plan Coordinator

Rev: 08/05/2016

9451 Corbin Avenue Suite 100 Northridge, CA 91324 **tel:** 800.321.2843 **tel:** 818.704.1444 **fax:** 818.704.9339