EAS
Employee Assistance Services

EAS CLAIM REIMBUSREMENT FORM

This form to be completed by insured employee				
Patient Name (if other than employee):	Male ☐ Female ☐	Patient Date of Birth:	Relationship to EE:	Patients Health Plan ID# PSD0000-
Employee Name:	Employee Date of Birth:		PSD Employee ID#:	PSD School/Site/Location
Home Address: City, State, Zip:	Employee Phone Numbers: Home _____ Cell _____		Is Patient Full Time Student? ☐ Yes ☐ No	If yes, name and city of school of attendance:

Are you, the patient or spouse, covered under any other group plan, health maintenance organization, government plan or insurance policy which will also pay for any of the expenses of this claim? ☐ Yes ☐ No If yes, give name, address and policy number of plan providing benefits:

Name and Address: _____ Policy #: _____

A. Authorization to Release Information

I certify that this information is complete and accurate and authorize release of mental health information necessary to process this claim. A photocopy of this authorization shall be as valid as the original.

X _____
Patient or Parent (if minor) Date

B. Please pay benefits under this claim directly to:

☐ Hospital ☐ Provider ☐ PSD Employee

I hereby authorize payment of benefits directly to any provider(s) of service otherwise payable to me but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

HOW TO FILE A CLAIM:

1. TIMELY FILING: Claims must be submitted within 180 days of the date of service.
2. Complete all questions/sections of this form. If all questions are not answered, a delay may occur in the consideration of this claim.
3. Attach this form to your providers claim form/billing statement.
4. Fax completed forms to EAS at 970-488-4933 -or-
5. Email completed forms to EAS@psdschools.org, -or-
6. Mail completed forms to:

Employee Assistance Services
2850 McClelland Drive Suite 2200
Fort Collins CO 80525

IMPORTANT:
Provider's claim form/billing statement must contain all of the following information:

- **Patient name**
- **Patient date of birth**
- **Patients PSD Health Plan ID#**
- **Date(s) of service**
- **CPT code for each date of service**
- **Charges for each date of service**
- **ICD10 diagnosis code**
- **Providers name, credentials, address, phone**

DO NOT PRESENT CANCELLED CHECKS, CASH RECEIPTS, OR CREDIT CARD RECEIPTS

Before sending this claim form:

1. **Is the provider of services *licensed* in the state in which they are practicing? This is required for benefits reimbursement.**
2. **Does your provider's bill indicate what services were rendered and for whom?**
3. **Have you answered all the questions applicable to your claim?**
4. **Questions? Contact EAS at 970-488-4925**