RESET

State Health Benefits Program (SHBP) / School Employees' Health Benefits Program (SEHBP)

Request for Adjustment of Out-of-Network Behavioral Health Claims

The SHBP / SEHBP Commissions have directed Horizon Blue Cross Blue Shield of NJ to reconsider certain out-of-network claims for behavioral health services reimbursed between May 4, 2009 and March 23, 2014. If you received reimbursement for behavioral health services provided by an out-of-network behavioral health professional, other than a physician, **between May 4, 2009 and March 23, 2014**, while covered by SHBP/SEHBP, you may be entitled to additional reimbursement. Such claims consist of out-of-network sessions with a psychologist, licensed clinical social worker, licensed marriage family therapist, licensed professional counselor, or clinical nurse specialist.

To pursue a request for adjustment of these claims, you will be required to complete this form and either provide documentation demonstrating that you paid the difference between the Horizon BCBSNJ reimbursement and the out-of-network provider's full charge for these services or complete and sign the certification on the reverse side of this form. [Examples of acceptable proof that you paid your provider include provider billing statements clearly reflecting payments made, cancelled checks, or credit card receipts.] Horizon BCBSNJ has a separate form to provide you with your dates of service, provider contact information, amount claimed and amount reimbursed. You may submit that separate form to receive the requested information prior to completing and filing this form.

Please mail your documentation and this completed form by December 31, 2021 to:

Horizon BCBSNJ
PO Box 820
Newark, NJ 07101-0820

Member Name:	
Identification number:	**3HZN** ___ ___ ___ ___ ___ ___ ___ ___
Member Address:	
Patient Name:	
Date(s) of Service/Treatment span:	
Provider Name:	
Provider Address:	
Provider TIN (Tax Identification Number)if known:	
Description of Proof Submitted:	

Please sign the reverse side of this form.

Member Name (please print): _____ Date: _____

Member Signature: _____

Please allow 45 days to receive a response to your request.

Where you do not have cancelled checks or receipts corresponding to visits during the relevant time period; or you do not have current billing from the provider showing visits with the amount still due, you may instead submit the following certification:

Certification

I, _____, received services from _____

(Member name) *(Name of mental health provider)*

between _____ and _____; and

(date) *(date)*

I have either paid the full amount billed by my provider or still owe my provider the balance of the bill above the amounts already reimbursed by Horizon; and

I understand my obligation to pay to my provider any additional amount reimbursed by Horizon unless I have already paid the full amount billed by the provider; and

I certify that my statements are true and understand that I am subject to penalty if the statements are determined to be intentionally false or misleading.

_____ _____

Member Name (Printed) *Date*

_____

Member Signature