

## **Acknowledgment for Out-Patient Mental Health Referrals Utilizing The UCSD Student Health Insurance Plan (SHIP)**

As a result of your recent evaluation at Counseling & Psychological Services (CAPS), we have concluded that your mental health care can be best provided using an off-campus resource.

Health insurance benefits for off-campus care are available for enrolled undergraduate and graduate students through the Student Health Insurance Plan (SHIP). A written referral from CAPS is required in order to access benefits. Eligible services are subject to a \$200 plan year deductible for all outpatient services. In addition, there is a \$15 co-pay for each visit. Once the deductible and co-pays have been satisfied, the plan pays eligible charges as follows: UCSD providers are paid 100%, network providers at 80%, and all other providers are paid at 60%.

Your CAPS psychologist can recommend several providers from whom you may choose. Alternatively a single off-campus UCSD provider may be selected. If you prefer, you may choose a provider you know or a network provider by accessing the panel website at <http://cfmcnet.org> as long as your CAPS psychologist believes that the proposed off-campus provider has suitable qualifications.

You are encouraged to contact your chosen provider(s) to discuss appointment availability. It is also suggested that you determine if the provider is willing to submit claims directly to the insurance company for payment of services rendered, which would avoid the necessity of you paying for the services directly and awaiting reimbursement. Once you have finalized the selection of your off-campus provider you must inform your CAPS psychologist of your choice so that we can send the written referral to that provider, subject to final approval. Your CAPS psychologist will inform you when the written referral is approved.

### **Important information about your referral:**

A written referral is valid for 1 year, unless a shorter time frame is specified, from the date signed.

A written referral is valid for the specific number of visits indicated.

A new referral is required when a referral has expired or all visits have been exhausted.

A new referral will be required if there is a change of provider from what was originally requested.

Retroactive referrals are not available for services rendered prior to the date that the referral is written.

Retroactive referrals will not be provided for services rendered after a referral has expired.

A written referral does not guarantee benefits or coverage.

For further questions regarding your health plan benefits, please review the SHIP brochure, available on line at <http://studenthealth.ucsd.edu/content/pdfdocs/ship0708.pdf>, or contact the Student Health Insurance office at 858-534-2124.

### **Provision of Treatment Information To Your Off-Campus Provider**

You may select a provider in a meeting with the referring CAPS psychologist or communicate your final off-campus provider selection to the psychologist at a later date. We will send the written referral which will allow for insurance consideration and communicate case information that may be beneficial to your treatment with your selected off-campus provider. We will only provide that information after you have advised us, either at the initial meeting, or subsequently, of your selection. If additional mental health care is required beyond the limits set by the initial referral, either with the same or a different provider, case information may also be disclosed for subsequent referrals.

I acknowledge that I have received, read, understand the above information and had all my questions answered to my satisfaction.

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Print Name

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Signature

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Date

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Print Name

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Signature

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Date

# CLAIM FORM

Coverage Verified

**Mail To:** P.I.A. Inc.  
P.O. Box 6040  
Agoura Hills, CA 91376-6040  
(800) 468-4343

**Notice:** Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.

COMPLETE IN DETAIL  
TO INSURE  
PROMPT HANDLING

- PLEASE PRINT ALL INFORMATION -  
**MUST BE COMPLETED AND SIGNED BY STUDENT**

(Check One)

University of California, San Diego  
Please check appropriate box to indicate  
Policy number.

- Graduate, Pharmacy, and Professional  
Policy No. AMH0068158
- Undergraduate (including Foreign Undergraduate)  
Policy No. AMH0068168

National Union Fire Insurance Company of Pittsburgh, Pa.

Insured Student's Name (SHS – Please use patient label)

Student PID Number: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Present Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code + 4: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

**ARE YOU COVERED (as an insured or dependent) BY ANY HOSPITAL AND/OR MEDICAL PLAN OTHER THAN UCSD STUDENT INSURANCE?**     YES     NO

If yes, name of plan \_\_\_\_\_

**Date of accident or  
sickness**

**Date of first  
treatment**

**Nature of sickness or injury**

**Was sickness or injury related to an NCAA ICA Sport or Club Sport?**     Yes     No

**If yes, please explain:**

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.

To any medical care provider, medical care facility, Insurer, government sponsored health plan, or employer: I permit (while my claim is pending) the release of any medical information about me to the **Company** and its representatives. The Company's representatives include **Personal Insurance Administrators, Inc.**, reinsuring companies and other persons or groups performing business or legal services relating to my claim. This applies to information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one. I certify that the above information given by me in support of this claim is true and correct.

**PATIENT'S SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_