

Wildland Firefighter Service Report Form

Instructions: To receive payment for this case, you must complete the information requested on both pages of this form in its entirety. For detailed instructions, <u>see page 3</u>. Fax or mail the completed form within 60 days upon completion of services. See below for the billing address or fax.

Provider Information:						
MIS#:	TIN/SSN:					
Clinician Name:						
Group/Agency/Organization	:					
Street Address:						
City:			State:		ZIP code	:
Participant Information:						
Case#/MAT#:						
Participant Name:						
Date the participant contact Date of first available appoir 1. Enter the Date and Time S was virtual or in-person: Initial Assessment (Session Date MM / DD / / / Counseling Sessions	ntment offered (eventeen for each session for each sessio	n if particip on except fo In-Person	r Initial Assessment	enter date o	/ only) and	
Session Date(s)			` ,	Time Seen		
			MM / DD / YY			
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2. Is th	is an interim or final bill? Cheon \square Final Bill \square	ck the applicable	e box:				
3. Indi	cate the assessed problem (en	nter P=Primary, S	=Secondary):				
	Alcohol Anxiety	Depression	_ Illicit Drug	PTSD T	rauma		
	Occupational Stress Si	uicide Ideation _.					
4. Was	the participant referred to an	ny of the followir	ng? Check the app	olicable box:			
	EAP□ Managed Care □ E	mergency Servic	es 🗆 Medicatio	n Managemer	nt 🗆		
	Substance Abuse Disorders Treatment \square						
5. DSN	Л-5 Assessment (Axis 1):						
	Primary Diagnosis Seco	 ondary Diagnosis	5				
6. The	information above accurately	reflects the serv	vices I delivered.				
					//		
	Clinician Signature				Date MM/DD/YY		
	Telephone Number						

Submit form to:
 Magellan Healthcare
Wildland Firefighter Behavioral Health Program
Federal Programs Attn: Affiliate Specialist, MO22
 PO Box 1899
Maryland Heights, MO 63043

Fax: 1-888-656-5032

Wildland Firefighter Service Report Form Instructions

To receive payment for services rendered, you must complete the information requested on the Wildland Firefighter Service Report Form in its entirety.

MIS Number: Enter your Magellan provider MIS number. Your MIS number is the provider identification number Magellan assigned to you. Your MIS number is printed on many materials you receive from Magellan including your contracting or credentialing material and includes a bar code at the bottom of the document. Your MIS number is the first nine digits after the barcode (usually ending in "000"). Some contracting or credentialing documents refer to the MIS number as the "MBH Control No." If you're unsure of your MIS number, contact the Provider Services Line at 1-800-788-4005.

TIN/SSN: Provider's Taxpayer Identification Number (TIN) against which this reimbursement request is to be filed. Depending on how your practice is set up, this could be a federal TIN or your personal Social Security Number.

Date the participant contacted you for the first session: Provide the date the participant called or emailed to request an appointment.

Date of the first available appointment: Provide the date of the first available appointment you were able to offer the participant, even if the participant could not attend on that date.

Question #1: This question requests specific information regarding session times.

Session Date(s): Use MM/DD/YY format.

Time Seen (minutes): Indicate the number of minutes spent with the participant during the session noted in the session date. *Note: Participants have an initial assessment and up to 16, 50–60-minute sessions per year. In certain circumstances, participants may receive trauma counseling modalities that could require longer sessions (e.g., 90-minute sessions for prolonged exposure). For instance, prolonged exposure protocol may be available for up to 10 sessions, 90 minutes each.*

Virtual or In-Person: Indicate if the session was virtual or in-person.

Question #2: Is this an interim or final bill? – Check only one box.

- An interim bill means that you have seen the client for some but not all sessions.
- A final bill means that you have seen the client for all sessions, and you are submitting the final bill.

Question #3: Assessed problem: Enter a "P" in the box for primary problem and "S" for secondary problem.

Question #4: Was the participate referred – If a referral was necessary, indicate the type of referral needed by checking the applicable box.

Question #5: *DSM-5 Assessment* – If there is a secondary and/or tertiary diagnosis, enter them here. Review information at www.MagellanProvider.com. From the Getting Paid tab, chose DSM-5/ICD-10.