

# 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, [see page 3](#). 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 contacted you for first session: \_\_\_\_\_ MM / DD / YY  
 Date of first available appointment offered (even if participant did not accept): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1. Enter the Date and Time Seen for each session except for Initial Assessment (enter date only) and indicate if session was virtual or in-person:

**Initial Assessment (60 minutes):**

Session Date	Virtual	In-Person
MM / DD / YY	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>

**Counseling Sessions (up to 16 sessions, 50-60 minutes, OR up to 10 sessions, 90 minutes):**

Session Date(s)	Time Seen			Session Date(s)	Time Seen		
MM / DD / YY	(minutes)	Virtual	In-Person	MM / DD / YY	(minutes)	Virtual	In-Person
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>
____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Is this an interim or final bill? Check the applicable box:

Interim Bill  Final Bill

3. Indicate the assessed problem (enter P=Primary, S=Secondary):

Alcohol \_\_\_\_ Anxiety \_\_\_\_ Depression \_\_\_\_ Illicit Drug \_\_\_\_ PTSD \_\_\_\_ Trauma \_\_\_\_  
Occupational Stress \_\_\_\_ Suicide Ideation \_\_\_\_

4. If this is a final bill, were the participant's assessed problems successfully addressed in sessions? Yes  No

If No, did you refer the participant to any of the following? Check the applicable box:

EAP  Managed Care  Emergency Services  Medication Management   
Substance Abuse Disorders Treatment

5. DSM-5 Assessment (Axis 1):

\_\_\_\_ - \_\_\_\_      \_\_\_\_ - \_\_\_\_  
Primary Diagnosis      Secondary Diagnosis

6. The information above accurately reflects the services 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  
P.O. 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: Were the participant’s assessed problems successfully addressed in sessions? If not, was the participant 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](http://www.MagellanProvider.com). From the Getting Paid tab, chose DSM-5/ICD-10.