

## **SHIP Mental Health Referral Prior Notification to SHC Insurance Office Required**

When a student with GSHIP is referred to a Community Mental Health provider, the following protocol should be followed:

1. The student chooses a Mental Health provider from the community referral resource directory provided by the Mental Health clinician or from the Anthem PPO Network website.
2. The student should check the community provider's status within Anthem Blue Cross Network: It is the student's responsibility to make sure the provider of service is part of the Anthem Network of Preferred Providers. Students may call Anthem Blue Cross Customer Service at **866-940-8306** or access the website at: [www.ucop.edu/ucship](http://www.ucop.edu/ucship). For maximum benefit coverage, members should receive care within the Anthem Blue Cross PPO Network.

**Costs:** The office visit **co-pay** for an in-network or non-network provider is **\$15.00**.

**Please Note\*\*Services by an out of network provider are subject to a \$300.00 deductible, in addition to the \$15.00 copayment.** Once this deductible is met your insurance will cover the charges at 60% of the allowed amount. When making your appointment please establish fee and billing questions.

3. The student schedules an appointment with a selected community provider. The student should confirm with the provider that he/she is currently a preferred provider in Anthem Blue Cross
4. **The student must submit this form within a week of making the appointment, complete with the required information below to the Student Health Center Insurance Office either by:**
  - Mail: UC Irvine Student Health, 501 Student Health, Irvine, CA 92697-5200
  - Fax: 949-824-5062
  - Or, drop off the form to the Insurance Office located at Student Health Center.

The notification to the SHC Insurance Office authorizes the visit to the community to be considered for review for payment. Authorization from the SHC Insurance Office is not a guarantee of payment. All claims submitted are subject to review under the terms and conditions of the policy.

**If this protocol is not followed, charges billed by the provider may not be paid by the Insurance Company. The student may be held responsible for 100% of the charges IF he/she failed to notify the SHC insurance office by submitting this form.**

**For further questions, please call the Insurance Office at 949-824-2388.**

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**To be completed by the Referring Provider:**

**Provider Name:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_

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**To be completed by the Student/Patient: Student Name:** \_\_\_\_\_

**Student ID #:** \_\_\_\_\_ **Community Provider Name:** \_\_\_\_\_

**Community Provider Address:** \_\_\_\_\_ **Provider's Phone #:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_ **Appointment Time:** \_\_\_\_\_ **Provider's FAX:** \_\_\_\_\_