SIMS Foundation P.O. Box 2152 Austin, TX 78768-2152
Confidential Client/Provider Numbers **Phone 512-494-1007**
Fax 512-542-9965
www.simsfoundation.org

PROVIDER CLAIM FORM

(Please Print)

Date claim sent by Provider:	Sent by: Fax E- Mail
Provider Name:	
Group Practice Name:	
Mailing Address (if changed):	
City, State, Zip:	
Phone #:	Fax # (if confidential):
UPDATE: How many SIMS clients do you have on your caseload at this time?	
If you are willing to accept more SIMS clients, how many?	
☐ *I certify that my professional licensure(s) and/or permit(s) to practice are current as of this date.*	
☐ *I certify that my professional liability and/or malpractice insurance is current as of this date.*	

PROVIDER BILLING SCHEDULE

Category of Sessions: **A**-Initial Visit/Assessment; **I**-Individual; **C**-Couple; **F**-Family; **M**-Minor Child/Adolescent; **G**-Group

Client Co-Pay		**$15**	**$20**	**$25**	**$30**	**$35**	**$40**
SIMS Co-Pay		**$30**	**$25**	**$20**	**$15**	**$10**	**$5**
Total Amount to Provider		**$45**	**$45**	**$45**	**$45**	**$45**	**$45**

PLEASE NOTE: Initial Sessions are reimbursed at the rate of $55, so remember to add the extra $10 to SIMS portion of the co-pay. Do not add the $10 to the client co-pay.
GROUP SESSION REIMBURSEMENT RATES ARE $35.00 with the client paying the normal co-pay amount up to $35 and SIMS paying the remainder, if any.

CLAIM SECTION

Client #	Date of Service	Category of Session	Session Number	Client Co-Pay	SIMS Co-Pay	Total to Provider	*SIMS STAFF ONLY*	
							Auth	*Comment*

Submit claims within 30 days of services; payment of claims submitted 45 days beyond the date of service may be delayed; *claims submitted 90 days after the date of service* ***will not be paid***. If you have questions about submitting claims, please contact our clinical staff on the confidential client/provider line at 512-494-1007.