

BCBS Insurance Verification Form

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A. Please complete the highlighted information and fax or email this information to me *prior* to your first appointment.

Insured's name as it appears on the plan: _____

Insured's ID#: _____ **Birthdate:** _____

Insured's Employer/Policy Group Name or #: _____

Patient's Name: _____ **Birthdate:** _____

Insurance Plan Name: _____ **PPO HMO POS Other**

Who manages behavioral health services in your plan? BCBS or Magellan

Is there a separate behavioral health deductible to meet? YES NO

Effective date of insurance coverage: _____ **Copay:** _____

Is pre-authorization required for services? YES NO

Insurance phone # (see the back of your insurance card): _____

Please bring a copy of your insurance card to the first appointment.

B. To be completed by my office:

Date of benefits verification: _____ **Insurance rep:** _____

Pre-existing condition? YES NO **Visits allowed per year** _____

Visits pre-authorized (if applicable): _____ **For the period:** _____

Authorization#: _____ **Authorization#** _____

Treatment Plan Required? YES NO **When?** _____

Current Medications: _____

Other Notes: _____
