

BCBS Insurance Verification Form

clbockwitz@aol.com or 1.413.513.9503 (Fax)

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 \$: _____
(NOTE: Your mental health co-pay may be different from your medical co-pay)
Is pre-authorization required for services? YES NO
BCBS phone # (see the back of your insurance card): _____

B. To be completed by my office:

Date of benefits verification: _____ BCBS rep: _____
Pre-existing condition? YES NO Visits allowed per year _____
Visits pre-authorized (if applicable): _____
Authorization#: _____ Authorization# _____
Treatment Plan Required? YES NO _____
Diagnosis: _____

Current Medications: _____

Other Notes: _____

