BlueCross BlueShield of Alabama

American Behavioral

BlueCross BlueShield Blue Card (ITS) Program Verification Worksheet

SECTION ONE: PATIENT INFORMATION

Patient's Name: _____ **Patient's DOB:** _____ **Patient's Age:** _____

Member Number: _____ **Contact #1:** _____ **Contact #2:** _____

SECTION TWO: SUBSCRIBER INFORMATION

Subscriber's Name: _____ **SSI:** _____

Member Number: _____ **Place of Employment:** _____

SECTION THREE: INSURANCE VERIFICATION

1. **Verify that this is a BlueCross BlueShield member with out-of-state insurance, and that either picture shown below is printed on the insurance card.**

Verified? ☐ **Yes** ☐ **No**

2. **Call BlueCross BlueShield at 1-800-676-BLUE (1-800-676-2583).**

3. ***IMPORTANT*: Please identify yourself as a BlueCross BlueShield provider subcontracted under American Behavioral. Also, please have the 3-digit alpha prefix listed before the member number on the insurance card. This prefix ensures you are routed to the correct customer service center.**

   3-digit alpha prefix: _____

4. **Is this patient on COBRA?** ☐ **Yes** ☐ **No**

5. **# of Days/Visits Per Benefit Period:** _____ **Copay:** _____ **Deductible:** _____

   Details: _____

   _____

6. **Does This Policy Require Precertification?** ☐ **Yes** ☐ **No**

7. **If So, Who Is Called To Pre-certify? (i.e. Value Options, Etc.)** _____ **Phone #:** _____

8. **Provider Level Covered:** ☐ **M.D.** ☐ **D.O.** ☐**Ph.D.** ☐ **Psy.D.** ☐ **LCSW** ☐ **LPC** ☐ **Other:** _____

SECTION FOUR: AUTHORIZATION INFORMATION

Authorization Contact Name: _____

Authorization # _____ **# of Visits:** _____

Beginning Date: _____ **Expiration Date:** _____

SECTION FIVE: NOTES AND EMPLOYEE SIGNATURE

Notes: _____

_____

Provider Employee Signature: _____