

BCBS Verification Form

Patient Name: _____

Date of Birth: _____

Contact Name: _____ Phone Number: _____

Please call BCBS at the Customer Service number indicated on your Insurance ID card and ask for **BEHAVIORIAL HEALTH BENEFITS DONE IN AN OFFICE FOR THERAPY AND PSYCHOLOGICAL TESTING (OUTPATIENT MENTAL HEALTH)**. The name of our practice if needed is **ATLANTA AREA PSYCHOLOGICAL ASSOCIATES**.

State Home Plan of Policy: _____ Policy Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Is Policy a: PPO POS OR HMO (Circle One) Effective Date: _____

Exclusions: _____

Deductible: Individual: _____ amount met: _____

Family: _____ amount met: _____

Deductible apply to therapy? Yes or No (Circle One)

Deductible apply to psychological testing? Yes or No (Circle One)

Coinsurance: _____ applies to therapy? Yes or No (Circle One)

Coinsurance: _____ applies to psychological testing? Yes or No (Circle One)

Copay: _____ applies to therapy? Yes or No (Circle One)

Copay: _____ applies to psychological testing? Yes or No (Circle One)

Out of Pocket: Individual: _____ amount met: _____

Family: _____ amount met: _____

Authorization Required for Therapy? Yes or No (Circle One)

(CPT Codes for therapy: 90791, 90834, 90837, 90847)

Authorization Required for Testing? Yes or No (Circle One)

If yes, how is this obtained? _____

(CPT Codes for psychological testing 96130, 96131, 96132, 96133, 96136, 96137)

Visit Limit: _____ Hour Limit: _____

BCBS Representative Name: _____

Date of call: _____

Reference Number: _____

Send the completed form to: kroche@atlantapsych.com or fax to 770-953-6015. When we verify the form is complete, we will call you to schedule your appointment.