BCBS Coverage 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 **BEHAVORIAL 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)

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