BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

BEHAVIORAL HEALTH MANAGEMENT PRESCREENING FORM

Patient Information

First Name	Middle Initial	Last Name	
Date of Birth	Contract Number (include prefix)	Group Number	Sex: ☐ Male ☐ Female
Home Telephone	Work Telephone	E-mail	

Diagnosis Information

Axis I			
Axis II			
Axis III			
Axis IV			
Axis V			
Level of Care: (circle one)	☐ Partial Hospitalization Program (PHP) ☐ Residential	Anticipated Date of Admit	Estimated Length of Stay

Physician Resources

Physician First Name	Middle Initial	Last Name	
Individual NPI *(National Provider Identifier)*		Physician Tax ID Number	–
Facility Name		Facility Tax ID Number	–
Address			Local Blue Cross Participant: ☐ Yes ☐ No
City	State	Zip	County
Financial Contact First Name	Middle Initial	Last Name	
Financial Contact Telephone Number	Financial Contact Fax Number	Financial Contact E-mail	
Contact First Name	Middle Initial	Last Name	
Contact Telephone Number	Contact Fax Number	Contact E-mail	

I certify this information is complete and correct to the best of my knowledge. ______________________ Authorized Representative of Provider Signature ______________ Title __________ Date

Please return this form and clinical information to:

Mail	Fax	
Blue Cross and Blue Shield of Alabama Attn: Behavioral Health Services 450 Riverchase Parkway East Birmingham, AL 35244	**Blue Cross and Blue Shield of Alabama** Attn: Health Management **1-816-237-2397**	**Benefit Verification:** **1-800-248-2342**