BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

BEHAVIORAL HEALTH/SUBSTANCE ABUSE CERTIFICATION FORM

Patient Information

Patient Name	Date of Birth	Date of Admission
Subscriber Name	Contract Number (Including prefix)	

Physician Information

Physician Name	Tax ID Number	
E-mail	Telephone Number	Fax Number
Office Address		
City	State / Zip / County	

Hospital Information

Hospital Name	Tax ID Number	
Office Address		
City	State / Zip / County	
Contact Name		
E-mail	Telephone Number	Fax Number

Admission Information

Type of Admission ☐ Emergency ☐ Partial ☐ Intensive Outpatient (IOP) ☐ Elective/Scheduled

Presenting Factors (with Axis I)

Previous Treatment

For Substance Abuse

Blood Alcohol Level (BAL)	Urine Drug Screen (UDS)	Vital Signs

Treatment Plan

Medications	Estimated Length of Stay

Specific Discharge Plans

Fax the signed and completed form to: 1-816-237-2397.

I certify this information is complete and correct to the best of my knowledge.

Signature _____ Title _____ Date _____

(Rev. 02/2014)