BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Psychiatric / Substance Abuse Certification Form

FAX # 866 218-6536 ; 205 220-6536
* For Federal Certification Fax to 205 220-6605

Name of Patient:	Date of Birth:	Date of Admission:	
Subscriber Name:	Contract Number: (including alpha prefix)		
Physician Name:	Tax ID Number:	Physician Phone Number:	
Office Address:	City:	State:	Zip Code:
Hospital Name:	City:	State:	Zip Code:
Tax ID Number:	Admitting Diagnosis:		
Contact Name:	Telephone Number:	Fax Number:	
Type of Admission: Emergency:_____ Partial_____ IOP:_____ Elective / Scheduled:_____			
Presenting Factors:			
Previous Treatment:			
FOR SUBSTANCE ABUSE:			
BAL: UDS: VITAL SIGNS:			
Treatment Plan:			
Medications:			
Estimated Length of Stay:			
Specific Discharge Plans:			

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