BlueCross BlueShield of Texas

Request for Verification Of Benefits

Please complete this form in its entirety.
Any omitted fields (other than the optional information) will result in this request being incomplete and unable to be processed.

Date of Request: _____

Patient name: _____

Patient ID number: _____

Patient date of birth: _____

Name of enrollee or subscriber: _____

Enrollee or Subscriber ID number: _____

Patient relationship to Enrollee or Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Other

Presumptive diagnosis: _____ or presenting symptoms: _____

Procedure code(s): _____ _____ _____ or description of proposed procedure(s): _____

Place of service (if other than provider's office or location, name of Hospital or Facility where proposed services will be provided):
_____

Proposed date(s) of service: _____ - _____

Group number: _____

If known to the provider, name and contact information of any other carriers:

a) Carrier's name: _____
b) Carrier's address: _____
c) Carrier's telephone number: (_____) _____-_____
d) Name of enrollee: _____
e) Plan or ID number: _____
f) Group number: _____
g) Group name: _____

Name of provider providing the proposed service: _____

Please provide the following additional information in order to expedite your request:

National Provider Identifier (NPI) Number(s): _____

If already obtained, precertification and/or referral number for proposed services: _____

Please mail completed form to the following address:

BCBSTX
Request for Verification of Benefits
P.O. Box 660044
Richardson, Texas 75266-0044

Upon completion of processing, written requests for verification will receive a written notice via U.S. Mail.

*Written requests for verification will only be accepted at this designated P.O. Box address. Verification requests mailed to any other address will not be accepted. In addition, this P.O. Box may not be used for claims filing or any other correspondence.

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