Blue Cross Blue Shield Intake Form

Name:_____ DOB: _____

Insurance ID #:_____ Group #: _____

Primary Insured's Name (if different): _____

Primary Insured's DOB (if different): _____

Primary Insured's ID #: _____

Relationship to Primary Insured: _____

Insured's Employer: _____

If you have secondary insurance, please include the type of insurance, ID#, and Group # here: _____

_____

Certification & Authorization

I authorize the release of any medical information necessary to process my claims.

Signature: _____

Date: _____

I request that payments be made directly to Sarah A. Leffler, MSW, LCSW, LLC.

Signature: _____

Date: _____