



## KIDLINK TREATMENT SERVICES

### Referral Call Center - Insurance Verification Form

Please include a copy of BOTH the front and back of all insurance cards.

This information requested below is to verify insurance benefits.

**Name of Youth being referred:** \_\_\_\_\_

Youth SSN: \_\_\_\_\_ Youth DOB: \_\_\_\_\_

Male/Female: \_\_\_\_\_ Grade: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

**Name of Insured Party:** \_\_\_\_\_

*(Name on Insurance Card / Subscriber's Name)*

Insured SSN: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Insured Home Address: \_\_\_\_\_

Insured Home Phone Number: \_\_\_\_\_

Relationship to Youth: \_\_\_\_\_

*(Parent, Grandparent, etc.)*

Insurance Carrier: \_\_\_\_\_

*(Aetna, BCBS, Cigna, etc)*

Identification Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Subgroup Number: \_\_\_\_\_

Provider Assistance Phone: \_\_\_\_\_ Authorizations Phone: \_\_\_\_\_

Mail, Fax, E-mail or Scan Documents to:

**KidLink Treatment Services**

110 Westwood Place

Brentwood, TN 37027

Phone: 877-454-3703 or 800-726-4032

Fax: 866-775-4208 or 615-250-2387

E-mail: [ktsreferral@uhsinc.com](mailto:ktsreferral@uhsinc.com)

[www.kidlinktreatmentservices.com](http://www.kidlinktreatmentservices.com)