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**
1000 Health Park Drive, Building 3, Suite 400
Brentwood, TN 37027
Phone: 877-454-3703 or 800-726-4032
Fax: 866-775-4208 or 615-250-2387
E-mail: ktsreferral@uhsinc.com
www.kidlinktreatmentservices.com