BlueCross BlueShield
of Illinois

Verification of Residential Treatment

Member Name: ________________________________
Birth Date: ____________________ ID#: _____________________
Date of Hospital Discharge: _______________________

Residential Treatment:

I have reviewed the above patient's medical records or claims and confirm that the member received residential treatment starting on ____________________ (first date following hospital discharge) for a mental health diagnosis.

Signature of Program Staff: ___________________________________
Program Name: _______________________________________

* The ambulatory Residential Treatment section must be completed entirely to be accepted.

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