ABA Benefit Request Form

Please fill out the form below and send to:

Fax: 860.687.9230

Email: ABA@Evernorth.com *(please do not send encrypted emails)*

*After receipt of your request, we will call you with benefit information as soon as possible.
*Typed responses are preferred.
*Please use this form only if you have 3 or more customers you'd like to verify benefits for. If you have less than 3, please call our Autism Care Coordination Team at: 1.877.279.7603.

Clinic Name: ______________________ Clinic Tax ID: ______________

Clinic Service Address: ______________________

Contact Person: ______________ Contact's Phone #: ________

Is the voicemail confidential? ☐ Yes ☐ No

Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:	Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:
Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:	Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:
Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:	Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:
Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:	Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:
Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:	Member's Name: ______ ID #: ______ or Primary SSN: ______ Date of Birth: ______ Member's Home Address:

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