

Specialized Outpatient Services  
Community Treatment Aid  
Referral form

Referral Information

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

Referral Source (name and agency): \_\_\_\_\_

Referral Phone: \_\_\_\_\_ Referral Fax: \_\_\_\_\_

Referral Address: \_\_\_\_\_

Client Information

Client DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Residing with (name and relationship): \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Service Information

Presenting Concerns:

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Diagnosis (if known): \_\_\_\_\_

Therapist: \_\_\_\_\_

Location of Services Requested:

In home    In office    Either location    Other location: \_\_\_\_\_

Insurance/Payment Information

Type of Insurance:

Medicaid   Which company:  Total Care  
Blue (Auth needed)

UHC

Healthy

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Office Verification/Authorization

Services Authorized: \_\_\_\_\_ Authorization Dates: \_\_\_\_\_

Authorization Number: \_\_\_\_\_ Representative Name: \_\_\_\_\_

Date/Time of Call: \_\_\_\_\_ Signature: \_\_\_\_\_

Number of Hours Requested Per Week: \_\_\_\_\_