

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:

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 ☐ UHC ☐ Healthy
Blue (Auth needed)

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: _____