

Jonesboro
Phone: 870.933.6886
Fax: 870.933.9395

Walnut Ridge
870.886.5303
870.886.7002

Highland
870.856.3021
870.856.3024

Osceola
870.622.0592
870.622.0782

Paragould
870.335.9483
870.335.9487

Pocahontas
870.892.1005
870.892.0078

Searcy
501.305.2359
501.305.2348

Trumann
Phone: 870.483.4003
Fax: 870.483.4009

Mountain Home
870.425.1041
870.425.1049

REQUEST FOR SERVICES

Date of Referral: _____ / _____ / _____ **Clinic Location:** _____

Referral Source: _____ **Phone #:** _____

School/Daycare: _____ **Grade:** _____ **Age:** _____

Name of Person Being Referred: _____ **M** **F**

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Msg. Phone:** _____

Parent/Guardian: _____

Problems/Behaviors Exhibited (Reason for Referral): _____

court ordered **recently suicidal** **recently homicidal**

recently in hospital **in foster care**

SSN: _____ / _____ / _____ **Date of Birth:** _____ / _____ / _____

PCP: _____ **Phone #:** _____

Medicaid #: _____ **Medicare #:** _____

For Private Insurance see back of form

Date called PCP: _____ / _____ / _____ **Spoke to:** _____ **Received:** _____

Date and Time Intake Scheduled: _____

MHP assigned to do Intake: _____

Date: ____/____/____ Spoke to: _____ Owes 1st visit \$ _____

Insurance Information

Name of Insured: _____ DOB: _____ Employer: _____

Relationship to Client: _____ Client Name: _____

Insurance Group #: _____ Policy or ID #: _____

Name of Insurance Company: _____

Insurance Phone#: _____

Address to mail claims: _____

Date of call: ____/____/____ Verified by: _____

Spoke with: _____ @ _____ Phone #: _____

Effective Date of Coverage: ____/____/____ Is this a PPO contract? Yes No

In Network Out of Network

Deductible: \$ _____ Met of Deductible: \$ _____ Rollover: \$ _____

Referral required: Yes No Precert required: Yes No

Precert phone #: _____ Spoke to: _____

Payment Guidelines: _____

Number of visits per year: _____ Will it cover MHP to do the intake: Yes No

MD PhD LCSW LMSW LAC LPC LPE RNC LMFT

Precert Number: _____ Dates: _____

MHP or Dr.: _____ Codes Approved: _____