REFERRAL FORM

Please print, fill out and fax.
**All information is required for authorization from insurance carrier.

PATIENT INFORMATION

NAME: _____ DOB: _____ SSN#: _____

PHONE: 1._____ 2._____3._____

PLAN: **( )** Aetna **( )** Community First **( )** CSHCN **( )** Superior **( )** TMHP **( )** Other: _____

MEDICAID/PLAN ID#: _____

DIAGNOSIS: 1._____2._____3._____

ICD-9: 1._____ 2._____ 3._____ PRECAUTION: _____

REQUESTED SERVICES

( ) OCCUPATIONAL THERAPY

( ) Evaluate and Treat **( )** Re-Evaluate and Continue Treatment

( ) Plan of Care / Frequency: _____

( ) PHYSICAL THERAPY

( ) Evaluate and Treat **( )** Re-Evaluate and Continue Treatment

( ) Plan of Care / Frequency: _____

( ) SPEECH THERAPY

( ) Evaluate and Treat **( )** Re-Evaluate and Continue Treatment

( ) Plan of Care / Frequency: _____

REQUESTING PHYSICIAN

Physician's Name: _____ Physician's Signature: _____

NPI #: _____ FAX #: _____

Email: _____ Phone: _____

Completed By: _____

ALIGHT PEDIATRIC THERAPY CLINIC, INC

San Antonio Clinic
Fax: 210-921-0009

New Braunfels Clinic
Fax: 830-626-2782