



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

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