HOPE Behavioral Health Referral Form

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Date of Referral:_____In-office appt or TeleTherapy ?_____

Name of Facility/Office Referring: _____

Referral Source Contact Name: _____

PRIORITY: ____Low (within 2 weeks) **___Medium** (see within 7 days) **____High** (see within 48 hours)

Patient's Name _____Gender Identification_____

DOB_____Parent/Guardian Name_____

Patient Phone _____Patient Email: _____

Patient Address: _____

Will this patient do PHP/IOP with your facility? Yes or No_____

If yes, when will PHP/IOP be complete? _____

Specific needs or requests for treatment with HOPE (DBT, Art Therapy, etc):

Patient's Insurance Company (these are the KY insurance plans we are contracted with):

( ) Aetna or Aetna Better Health Medicaid Insurance Member ID number:_____
( ) Anthem(including Anthem Medicaid) Insurance Member ID number:_____
( ) Cigna Insurance Member ID number:_____
( ) Custom Design Benefits Insurance Member ID number:_____
( ) Humana (Commercial & Medicaid) Member ID number:_____
( ) Kentucky Medicaid Insurance Member ID number:_____
( ) MedBen Insurance Member ID number:_____
( ) Medical Mutual Insurance Member ID number:_____
( ) Passport Medicaid Insurance Member ID number:_____
( ) WellCare Medicaid or Medicare Insurance Member ID number:_____
( ) United Health Care/UMR/Optum Insurance Member ID number:_____
( ) Self-pay/Cash ( ) Other Insurance_____

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