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CRESCENT COMMUNITY SERVICES
REFERRAL FORM

HEALTH PLAN NAME & MEMBER ID #:	Referring Provider Name / Address / Phone & Fax #:
Health Plan Phone/Fax #:	
Date of Request:	Referring Provider's NPI #:
Member Name and DOB:	Referring Provider's Signature:
Parent Name, Address & Phone #:	Referring Office Contact Person (Name, Phone & Fax #):
Treatment Requested: ☐ ABA Therapy ☐ Occupational Therapy ☐ Speech Therapy	Diagnosis (inc. ICD code):
Referred to (Service Provider): **CRESCENT COMMUNITY SERVICES, INC.** **dba Crecsent Autism Center** **2450 Box Canyon Drive** **LAS VEGAS, NV 89128** **Ph: (702) 202-2567 / Fax: (888) 353-7336**	Place of Service / Facility and Address: **CRESCENT COMMUNITY SERVICES, INC.** **dba Crecsent Autism Center** **2450 Box Canyon Drive** **LAS VEGAS, NV 89128** **Ph: (702) 202-2567 / Fax: (888) 353-7336**
Referral Valid for (1) Year From (date): Thru (date):	
Notes: ***Pertinent Attachments = Information to support the proposed diagnosis, treatment / procedure; i.e. current clinical findings (progress reports), results of laboratory testing, IEP, etc., must be submitted to prevent processing delays.***	

**** All sections of this form must be completed.***

Please fax completed form to (888) 353-7336, or email to admin@ccsnv.org.

CRESCENT COMMUNITY SERVICES INTERNAL USE ONLY		
Authorization: ***Yes*** ***No***	***Date of Authorization:***	***Pended / Denied: (Reason):***
Health plan contact name & phone #:	***Authorization Number:***	