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# CRESCENT COMMUNITY SERVICES
## REFERRAL FORM

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| **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:<br>☐ ABA Therapy ☐ Occupational Therapy<br>☐ Speech Therapy | Diagnosis (inc. ICD code): |
| Referred to (Service Provider):<br>**CRESCENT COMMUNITY SERVICES, INC.**<br>**2550 NATURE PARK DRIVE, SUITE 180**<br>**NORTH LAS VEGAS, NV 89084**<br>**Ph: (702) 202-2567 / Fax: (888) 353-7336** | Place of Service / Facility and Address:<br>**CRESCENT COMMUNITY SERVICES, INC.**<br>**2550 NATURE PARK DRIVE, SUITE 180**<br>**NORTH LAS VEGAS, NV 89084**<br>**Ph: (702) 202-2567 / Fax: (888) 353-7336** |
| Referral Valid for (1) Year<br>From (date):<br>Thru (date): | |
| Notes:<br><br>***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*** | | |
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| ***Authorization:*** ***Yes*** ***No*** | ***Date of Authorization:*** | ***Pended / Denied: (Reason):*** |
| ***Health plan contact name & phone #:*** | ***Authorization Number:*** | |