

378 West Chestnut St.

Suite 103

Washington PA 15301

Office (412) 660-7064

Fax (724) 249-2825

Dear Provider:

We have a mutual patient. In the interest of continuity of care, we ask that the behavioral health provider verify via fax the following information regarding the patients care. We need this information to ensure that the patient is compliant with their drug and alcohol counseling and to secure the prior authorization for the medication.

Please include the following details:

Date that treatment began

Frequency in which the patient is seen

Confirmation that they are being counseled specifically for drug and alcohol

The date of the next scheduled appointment

We ask that you fax this information 1x/month

PRS is strictly the medical side of treatment. We believe strongly that medication alone is not the answer for our patients. We greatly appreciate your time and attention to this matter. If you have any question or comments please contact our office at the listed number above.

Thank you,

Positive Recovery Solutions