PROVIDER CHOICE FORM
ASAM 2.1/IOP

Individual Information

Individual Name: _____
Date of Birth: _____ Medicaid ID: _____
Phone Number: _____

Explanation of Provider Choice

I have been informed of my right to choose my provider for ASAM 2.1/IOP services. I understand that I may choose any qualified provider enrolled with Medicaid and authorized by DBHDS. I understand I may change my provider at any time without penalty. Client Initials: ____

Provider Selected

Provider Name: Love of Lyfe, LLC
Service Type: ASAM 2.1/IOP
Provider Phone: (757)-840-6786
Provider Address: 5295 Greenwich Road Suite 105 Virginia Beach, Virginia 23462

___ Selected by Individual ___Selected with Assistance

Acknowledgment

By signing below, I acknowledge that I was informed of my right to provider choice and voluntarily select Love of Lyfe, LLC to provide my ASAM 2.1/IOP services.

Individual/Guardian Signature: _____

Date: _____

Staff Signature: _____

Date: _____