West Counseling, PLLC

Please Fax to admissions/intake at 704-461-4334

Referral Sheet

NAME _____ AGE ___ Male/Female DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

HOME PH _____ CELL PH _____

EMAIL:

Insurance Info:

Name of insured: _____ Policy/ID #:_____ Group #_____

Phone number:_____ Address:_____

Policy holder Name:_____ DOB:_____ Employer:_____

Co Pay:_____ Co Insurance:_____ Deductible_____

Secondary Insurance info:

Name of insured: _____ Policy/ID #:_____ Group #_____

Phone number:_____ Address:_____

Policy holder Name:_____ DOB:_____ Employer:_____

Co Pay:_____ Co Insurance:_____ Deductible_____

(If consumer is a child) PARENT/LEGAL GUARDIAN_____ Ph# _____

PARENT/LEGAL GUARDIAN_____ Ph# _____

Primary Care Physician office: Ph#

Fax#:

Referring Provider/NPI:

Referral Reason: **Date:**

SERVICE ORDERS: REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.
(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).
My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. __ Yes __No
- The licensed professional who signs this service order has reviewed the individual's record . __Yes __No

Signature: _____ License #: _____ Date: / /