HealthMates
Wellness Center

580 Lincoln Park Blvd Ste 344
Kettering, OH 45429
Phone: (937) 401-0144

PSYCHIATRIC REFERRAL

ATTENTION TO: **Melissa Theis**
RECEIVER FAX #: **(937) 496- 5480**

HealthMates provides full-service coordination, including prior authorization, benefits verification, treatment scheduling, and referring provider follow-up.

1. PATIENT INFORMATION

First Name: _____ Last Name _____ Date of Birth: _____

Address: _____ Phone Number*: _____

Town/City: _____ State: _____ ZIP Code: _____ Email: _____

*Can a voicemail be left at this number for an appointment? ☐Y/ ☐N

Primary Insurance: _____ Policy #: _____ Group #: _____

Policyholder Name: _____ Card/BIN #: _____

Caregiver's Name: _____ Caregiver's Phone Number: _____

Reminder: Please fax a copy of the insurance card with this referral. Your patient may have 2 insurance cards for pharmacy and/or medical benefit.

2. MEDICAL HISTORY

Diagnosis: _____

_____

Medical/Treatment History: **Medication History:**

_____ _____

_____ _____

_____ _____

Additional medical reports and supporting documents are included with this form. ☐Y/ ☐N

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name: _____ Phone Number: _____

Practice: _____ Email: _____ Fax Number: _____

Please notify me with updates regarding my patient through: ☐Phone/ ☐Email/ ☐Fax