Champion State of Mind

Mental Health Solutions Focused on You

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Client Referral Form

Please submit the following referral information to Champion State of Mind either by fax, phone, mail or in person. Communication information for such submissions can be found at the top of this form.

Identification

Client's Full Name: _____ **Date of birth:** _____ **Age:** _____

Nicknames or aliases: _____ **Social Security #:** _____

Gender: _____ **Male** _____ **Intersex** _____ **Female** **Gender Identity (optional):** _____

Home street address: _____ **Apt.:** _____

Mailing address (if different from street address): _____

City: _____ **State:** _____ **Zip:** _____

Home phone: _____ **Cell phone:** _____

E-mail: _____ **Any communication restrictions?** _____

Please mark <u>all</u> forms of communication we may use to contact the client (or legal guardian):

❑ **Text** ❑ **E-mail** ❑ **Phone Call** ❑ **Voice Mail** ❑ **Mail**

For Minor or Dependent Client

Legal Guardian Name(s): _____ **Relationship to client:** _____

Legal Guardian's demographic information is: ❑ **Same as client** ❑ **Different than client** ***(provide below)***

Home street address: _____ **Apt.:** _____

Mailing address (if different from street address): _____

City: _____ **State:** _____ **Zip:** _____

Home phone: _____ **Cell phone:** _____

Referral Information

Reason for Referral: _____

Previous Mental Health Diagnoses (if noted): _____

Client risk (of harm) disclosure: ❑ **High** ❑ **Moderate** ❑ **Minimal** ❑ **None**

Updated Jan 2018

***** In-Network** Aetna, Avera Health Plans, AmeriHealth Caritas, Amerigroup Iowa, Avera Health Plans, Blue Cross/Blue Shield, Cigna, County Social Services, HealthPartners, Medicaid Iowa, Midlands Choice, Tricare West (Only), United Healthcare. Medicare for some providers.***

Primary Insurance

Insurance Company | **Sponsor Information (*Who Carries this Insurance?*)**

Name: _____ **Name:** _____

Address: _____ **Date of Birth:**_____ **ID #:** _____

City, State, Zip: _____ **Social Security #:** _____

Phone: _____ **Address:** _____

Group Number/Name: _____ **City, State, Zip:** _____

Member ID#: _____ **Phone:** _____

Secondary Insurance

Insurance Company | **Sponsor Information (*Who Carries this Insurance?*)**

Name: _____ **Name:** _____

Address: _____ **Date of Birth:**_____ **ID #:** _____

City, State, Zip: _____ **Social Security #:** _____

Phone: _____ **Address:** _____

Group Number/Name: _____ **City, State, Zip:** _____

Member ID#: _____ **Phone:** _____

Who will be financially responsible for the client's account?

❑ **Self** ❑ **Spouse** ❑ **Mother** ❑ **Father** ❑ **Other:** _____

Referral Information

Referred by: _____ **Agency:** _____

Address: _____ **City, State, Zip:** _____

Phone: _____ **Fax:** _____

Supplemental Documentation

Please provide the following additional documentation: ***(check mark if applicable and if attached)***

_____ **Proof of insurance (e.g. copy of insurance card)**

_____ **Release of Information from referral source to Champion State of Mind**

_____ **Copy of client demographics/face sheet from referral agency/clinic**

_____ **Court documents mandating services**

Submission referral date: _____ **via:** ❑ **Fax** ❑ **Phone** ❑ **Mail** ❑ **In Person**