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

Type of Service: ☐ Mental Health ☐ Addiction/Substance Use ☐ Both Services

Reason for Referral: _____

Previous Mental Health or Substance Abuse Diagnoses (if noted): _____

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

Updated January 2020

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

Primary Insurance

Insurance Company

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Group Number/Name: _____
Member ID#: _____

Sponsor Information (*Who Carries this Insurance?*)

Name: _____
Date of Birth:_____ **ID #:** _____
Social Security #: _____
Address: _____
City, State, Zip: _____
Phone: _____

Secondary Insurance

Insurance Company

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Group Number/Name: _____
Member ID#: _____

Sponsor Information (*Who Carries this Insurance?*)

Name: _____
Date of Birth:_____ **ID #:** _____
Social Security #: _____
Address: _____
City, State, Zip: _____
Phone: _____

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

☐ **Client** ☐ **Spouse** ☐ **Mother** ☐ **Father** ☐ **Other:** _____

Referral Information

We greatly value your trust and confidence and sincerely appreciate your referral- Thank you!

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**