**Prelude Mental Health Counseling, LLC. Referral Form**

Referring Provider Information

Name of Referring Provider: _____
Address of Referring Provider: _____
Contact Number: _____ Fax Number: _____
Relationship to Client/Patient (Please Select One):

| | |
|---|---|
| PCP □ | Psychiatrist □ |
| Therapist □ | Hospital □ |
| Other: _____ ☑ | |

Client/Patient Information

First Name: _____Last Name: _____
Address: _____
Phone Number: _____ Email: _____
Reason for Referral: _____
_____
_____
Length of Time in Provider's Care: Years _____ Months _____
Insurance: Yes □ No □
If 'Yes': Name of Insurance Provider: _____
Is MH Covered on Insurance Policy: Yes □ No □ Unknown □
Would you like to be notified of scheduled appointment date/time. Yes □ No □

**Please attach signed copy of ROI.**

**Please read the following statements and initial:**

*I understand due to rules/licensing requirements set by Medicare, Prelude Mental Health Counseling, LLC. Is unable to file claims to Medicare and Medicare Advantage Plans. Please refer clients seeking MH therapy and who wish to use Medicare benefits to providers who have the following credentials: LCSW, PhD or Psy.D.*

_____ *(initial)*

*As the referring provide, please call to confirm receipt of faxed referral and ROI.*

_____ *(initial)*

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