HEALTH CONNECT AMERICA

Fax referral to: 423-631-0211or Scan & Email to: jcgroup@healthconnectamerica.com
Visit us online @ www.healthconnectamerica.com

REFERRAL FORM

_____OP _____IOP _____TN HEALTH LINK _____CCFT _____PSYCH/CLINIC _____ANDSS

Referring Agency Contact Information:
Name/Agency:_____
Relation to Client:_____
Phone: _____
Fax:_____
Email:_____
***Have you informed the family that you are referring them for services? Yes____ No___*

If Parent/Guardian/Self Referral: Date:_____
Who referred you:_____

Please list any diagnosis and code: _____
_____
School Child Attends:_____
Is the child on any medications? Yes/ no Please list:
_____
_____

Client: _____Date of Birth: _____
Social Security Number:_____Gender: Male____ Female____
Race: African-American ___ Asian _____ Caucasian ____ Latino___ Native-American_____ Other _____
Legal Status: Citizen____ Alien____ Tobacco Use: User____ Non-User____ Unable to Collect___
Choose Smoking Status: Current Everyday____ Current Some Days ____ Former Smoker ____ Never Smoked ____
Unknown if Ever Smoked ____ Heavy Tobacco Smoker ____ Light Tobacco Smoker ____
If under client is underage: Parent / Guardian: _____
Relationship: _____ Email:_____
Client Address: _____City_____ Zip Code_____
Home Phone Number: _____ Cell Phone: _____

Please provide brief explanation of concerns/symptoms or reason for referral to services:

_____
_____
_____
_____
_____
_____

Other relevant information about this referral:

_____
_____

Insurance Information: Type of Insurance: _____

Member ID Number: _____Term Date: _____
Is there a secondary insurance? Yes No
If yes, please indicate company and type of plan. _____
Has a letter of service denial been received from second insurance? _____ Date Received _____

For office use only:

☐ BK ☐ RTL ☐ UPLD
☐ INS ☐ CL ☐ EMAIL
☐ ASI ☐ TY ☐ CHT

Revised 10/2019