4242 Woodcock Drive (Suite 101) San Antonio TX 78228 | Phone: (210) 435-1000 | Fax: (210) 200-6056

Physician Referral Form

Please fill out form completely in blue or black ink

Type of Plan		Referral Type		Physician Information
	Chip		Routine	Referral Date ____/____/________ Provider #: ______________________
	EPO		Urgent	Primary Care Physician: ______________________________
	HMO		Emergency	Referring Physician: ______________________________
	PCCM		Out of Network	______________________________ Address City State Zip code
	POS		Revised Referral	Email: ______________________________
	PPO		Notification ONLY	Phone: ______________________ Fax: ______________________
	W/C		Other:____________	Physician Signature :______________________________
	Other:________		Other:____________	
	Other:________		Other:____________	

Diagnostic Codes Supporting A Referral **(Please Circle ALL Codes that Apply)**		
Speech Language Pathology	**Occupational Therapy**	**Either discipline**
F80.1 Expressive Language D/O **F80.2** Mixed Exp/Rec Language D/O **R48.8** Symbolic dysfluency/echolalic speech	**R20.8** Sensory disturbance **F82** Specific Motor/DCD **R27.9** Dyspraxia **M62.9** Hypotonia **F98.4** Stereotyped rep mvmts **F41.9** Anxiety NOS **F63.9** Impulse control D/O NOS **R45.1** Restless and Agitation **F51.9** Sleep Disorder	**R62.0** Delayed Milestones **F88** Global developmental delay **F81.9** Unspecified delays in development **R62.50** Inadequate development **R63.3** Feeding diff & Mismanagement

Insurance Information		
Primary Insurance Carrier:	Phone #:	Fax #:
Member ID#:	Group #:	
Insured Name:	D.O.B. ____/____/______	SS #: ______/______/_______
Secondary Insurance Carrier:	Phone #:	Fax #:
Member ID#:	Group #:	
Medicaid: Yes / No	If Yes, Medicaid #:	

Patient Information

Patients Name: ____

Patient D.O.B: ______/______/________ Sex: Male / Female Patient SS#: _______-_______-_________

Mother's Name: ______________________________ Father's Name:______________________________

____
Address City State Zip code

Home Phone #:____________________ Alternate Contact #: ______________________ Email:______________________

Primary language spoken by Parent: ______________________ Secondary language: ______________________

Primary language spoken by Child: ______________________ Secondary Language: ______________________

This referral does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits.