



REQUEST SUBMITTED ON (DATE): \_\_\_\_\_

MEMBER INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

CURRENT TREATMENT PROVIDER INFORMATION

Provider's Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Services Provided: [ ] Therapy [ ] Medication Management [ ] Other: \_\_\_\_\_ Date of Next Scheduled Visit (if applicable): \_\_\_\_\_ How long have you been in treatment with this provider? \_\_\_\_\_ How frequently are you seen by this provider? [ ] Weekly [ ] Monthly [ ] Other: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Services Provided: [ ] Therapy [ ] Medication Management [ ] Other: \_\_\_\_\_ Date of Next Scheduled Visit (if applicable): \_\_\_\_\_ How long have you been in treatment with this provider? \_\_\_\_\_ How frequently are you seen by this provider? [ ] Weekly [ ] Monthly [ ] Other: \_\_\_\_\_

Sent to Halcyon Behavioral on: \_\_\_\_\_ [ ] Mail [ ] Fax By (initials): \_\_\_\_\_

Mail: Halcyon Behavioral PO Box 25159 Fresno, CA 93729 or Fax: (559)492-2314