REFERRAL FORM
Aetna, Cigna, Blue Cross, Tricare

Childs First and Last name	
Child's DOB	
Child's age	
Child's gender	
Child's social security #	
Child age	
Child home address	
Primary insurance company & ID#	
Secondary insurance company & ID#	
Policy holder name	
Policy holder relationship to child	
Policy holder DOB	
Policy holder social security #	
Policy holder employer name	
Employer address:	
Parent /Caregiver name	
Parent/ Caregiver phone number	
Parent/Caregiver Email	
School/ Daycare Name	
School type check one	☐ Public ☐ Private ☐ Home/Virtual ☐ Daycare
Child primary care doctor Name and phone	
Service location type desired	☐ Home ☐ School/Daycare ☐ Clinic
Family Availability for Services Monday Tuesday Wednesday Thursday Friday Saturday Sunday	*Example: Monday only after school 3-9pm; Tuesday no availability*

****Notes**: Please send with the referral any of the documents below as per carrier guidelines:

1. A copy of the front and back of your insurance card.
2. Copy of last pediatric visit along with a list of current medications.
3. Developmental, Cognitive and Neurological evaluation if completed.
4. Adaptive behavior assessment if completed (Not required by all plans)
5. Proof of initial diagnosis

*Return completed forms and documents to: kmccabe@behaviorbasicsinc.com or fax: 772-219-1339