bonmente

MENTAL HEALTH REFERRAL

Patient Name: _____ Sex: ○M ○F ○Other:_____ Date of Birth: _____

Address: _____ City, State: _____ ZIP: _____

Phone: _____ Email: _____

Insurance Carrier (please select from the following):

- ○ Aetna
- ○ Anthem Blue Cross / PO
- ○ Anthem Blue Cross / Medi-Cal
- ○ Beacon
- ○ Blue Cross/Blue Shield
- ○ Cigna
- ○ Magellan Health
- ○ United Healthcare/United Behavioral Health
- ○ Other _____

Member Policy # : _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: _____

Is patient aware of psychiatric referral? ○Yes ○No

Provider Preference: ○No Credential Preference ○Psychiatric Nurse Practitioner ○Psychiatrist ○No Gender Preference ○Male ○Female

Reason for Referral: ○Medication Management ○Psychiatric Evaluation ○Other _____

Patient's Mental Health Diagnosis or Symptoms: _____

_____

Current Medications: _____

Referring Provider: _____ Phone: _____

Form Completed By: _____ Fax: _____

Please fax completed form to 424-237-3204 or email to referrals@bonmente.com.