UCP of Maine Referral Form

Please email all referrals to jared.dolley@ucpofmaine.org or fax to 207-941-2955

Client Name: _____ Date: _____

Full Home Address: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female ☐ Other: _____

Completed by: _____ Role: _____ Phone #: _____

Referring for:

☐ Children's Case Management ☐ Behavioral Health Home (Birth to 20)

☐ Home & Community Treatment (HCT) ☐ Outpatient Counseling: ☐ *Individual* ☐ *Group* ☐ *Family* ☐ *Assessment*

☐ Rehabilitative and Community Supports (RCS) Home ☐ Adult Case Management

☐ Bridges Services: ☐ *RCS Specialized School* ☐ *RCS School* ☐ *Day Treatment* ☐ *Speech Therapy/ Assessment* ☐ *FBA* ☐ *Outpatient Therapy*

Reason for referral (symptoms, behaviors, type of treatment or provider requested):

Please identify role and who has legal custody/guardianship to consent to treatment in left column:

Gaurdianship Ex: Parent, DHHS, Foster	Name	Address	Contact Number	Ok to leave message?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Mainecare Number (if different/additional insurance, see page 2): _____

Diagnostic Assessment: ☐ Yes ☐ No Completed by: _____ Date: _____

Diagnosis: _____

Case Manager: _____

Primary Care Physician/Office: _____

Other Agencies Involved: _____

For Outpatient Counseling clients only: Do you have transportation to appointments? ☐ Yes ☐ No

What days and times are you available to attend appointments?: _____

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How did you hear about UCP of Maine: ☐ Advertisement ☐ Newsletter ☐ Website ☐ Social Media ☐ Friend/Family Member ☐ Event ☐ PCP ☐ Other: _____

Additional Insurance Information

Primary:

Primary Insurance: _____ Primary Insurance Phone Number: _____

Claims Address: _____

Policy Holder Name: _____ Relationship of Policy Holder *(if different from self)*: _____

Primary Policy No.: _____ Primary Policy Group No.: _____

Secondary:

Secondary Insurance: _____ Secondary Insurance Phone Number: _____

Claims Address: _____

Policy Holder Name: _____ Relationship of Policy Holder *(if different from self)*: _____

Secondary Policy No.: _____ Secondary Policy Group No.: _____

For UCP of Maine use only:

Primary:

Effective Date of Coverage: _____ Deductible Amout: _____ Deductible Met: _____

Co-pay Amount: _____ Co-insurance Amount: _____ Annual Limit: _____

Managed Care Name: _____ Managed Care Phone No.: _____

Authorization Required: ☐ Yes ☐ No Authorization No.: _____

Total Sessions Authorized: _____ Authorization Start Date: _____ Expiration Date: _____

Secondary:

Effective Date of Coverage: _____ Deductible Amout: _____ Deductible Met: _____

Co-pay Amount: _____ Co-insurance Amount: _____ Annual Limit: _____

Managed Care Name: _____ Managed Care Phone No.: _____

Authorization Required: ☐ Yes ☐ No Authorization No.: _____

Total Sessions Authorized: _____ Authorization Start Date: _____ Expiration Date: _____