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: _____ Phone #: _____

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

Completed by: _____ **Role:** _____ **Phone #:** _____

Referring for:

- Children's Case Management
- Behavioral Health Home (Birth to 20)
- Adult Case Management
- Bridges Services: *RCS Specialized School* *RCS School* *Day Treatment* *Speech Therapy/Assessment* *FBA* *Outpatient Therapy*
- Home & Community Treatment (HCT)
- Rehabilitative and Community Supports (RCS) Home
- Outpatient Counseling: *Individual* *Group* *Family* *Assessment* *OPT Caravel* *OPT Suzanne Smith* *OPT Carmel Elementary*

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:

Guardianship 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?: _____

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 Amount: _____ 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 Amount: _____ 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: _____