



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:	<input type="checkbox"/> Therapy	Date of Next
	<input type="checkbox"/> Medication Management	Scheduled Visit
How long have you been in treatment with this provider?	<input type="checkbox"/> Other: _____	(if applicable):
	How frequently are you seen by this provider?	<input type="checkbox"/> Weekly
		<input type="checkbox"/> Monthly
		<input type="checkbox"/> Other: _____

Provider's Name: _____

Office Phone: _____ Office Fax: _____

Office Address: _____

Services Provided:	<input type="checkbox"/> Therapy	Date of Next
	<input type="checkbox"/> Medication Management	Scheduled Visit
How long have you been in treatment with this provider?	<input type="checkbox"/> Other: _____	(if applicable):
	How frequently are you seen by this provider?	<input type="checkbox"/> Weekly
		<input type="checkbox"/> Monthly
		<input type="checkbox"/> Other: _____

Sent to Halcyon Behavioral on: _____ Mail Fax By (initials): _____

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