TRICARE COUNSELING & CONSULTING, INC.
FAX# 866-279-1991

Referral/Service Order Form

Date: _____ Referred by:_____ Phone #: _____

Referring Provider ID/CA Access#: _____ Provider NPI: _____

Reason for referral:

[ ] Remains symptomatic	[ ] Disrespect of Authority	[ ] Legal Issues	[ ] Issues Addictive
[ ] Aggressive behavior	[ ] Anti-Social Behavior	[ ]ADD-ADHD Behavior	[ ] Psychological Stressors
[ ] Depressive/Anxiety Behavior	[ ] Non-Compliance	[ ] Mood Stability	[ ] Chronic Medical Problems

Other: _____

Client Information _____Adult _____Child Prefers: _____ In-home appt. _____ Office appt

Client Name (*First, MI, Last*): _____

DOB: ____/____/____ Gender _____Male ____Female SSN #: _____

Client Address:_____City_____ State_____Zip_____

Primary Phone #:_____ Alt. / Phone #: _____

For Children Only (please complete the following):
Parent/Guardian Name (s)/ Relationship:_____

Primary Phone #:_____ Alt. Phone #: _____

Insurance: ___**Medicaid** ___**Medicare** ___ **Health Choice** ___**BCBS** ___ **Tricare** ___**Cigna Behavioral**

Other: _____Member ID #: _____Effective date: _____

ORDER FOR MEDICAL NECESSITY (by referring provider)

Directions: PLEASE PROVIDE SIGNATURE FOR SERVICE ORDERED. EFFECTIVE DATE SHOULD BE THE DATE THE SERVICE WAS DETERMINED NECESSARY.

The services indicated below have been determined to be medically necessary for the client named above. This order for service does not indicate supervision of service provided or that the MD or Psychologist, NP, or PA has any role other than determining medical necessity, unless other points specified elsewhere (e.g.. treating psychiatrist).

Service Ordered	**Date of Order & Signature**	**Print Name Or Stamp**	**Signature of MD Phd, NP or PA with credentials – No Stamps**
Behavioral Health Outpatient Services			

TCC MR#: _____