ATLAS
Behavior Consulting LLC

5373 N Union Blvd, Ste 202, Colorado Springs, CO 80918
e: hayley@atlasbxconsulting.com p: 719.465.7195 f: 719.258.1353

Referral & Insurance Form

The following information must be completed and returned as a part of the intake process for ABA services. These are required for billing and insurance authorization purposes. Any incomplete sections will slow down the intake process and may cause delays in the start of services.

Please read and initial next to each statement. All steps must have been completed for the ABA Intake Process to be completed.

_____ Each patient must have an assigned primary care physician (PCP). Contact your insurance provider to get a PCP assigned if your child does not already have one assigned.

_____ The patient has proof of a qualifying diagnosis by a medical doctor (MD).

_____ The patient has an active referral for Applied Behavior Analysis, prescribed by a medical doctor and/or psychiatrist.

Patient Information

Patient Name: _____
Patient DOB: _____
Patient School/Grade: _____
Does the patient have an active IEP? _____
What placement setting does the patient have at school? (Ex: Full/part time general education, self-contained classroom, etc) _____

Caregiver Information

Parent/Guardian Name(s): _____
Parent/Guardian DOB: _____
Primary Phone Number: _____
Secondary Phone Number: _____
Email: _____
Home Address: _____

Insurance Information

Primary Insurance: _____
Member ID #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber's Place of Employment: _____
Subscriber's Relationship to Child: _____

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Secondary Insurance: _____
Member ID #: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber's Place of Employment: _____
Subscriber's Relationship to Child: _____

Referral Information

Primary Care Physician: _____
Address: _____
Phone: _____
Fax: _____
Diagnosing/Referring Provider Name: _____
Current Diagnosis: _____