NC CENTER FOR COUNSELING AND PSYCHOLOGICAL SERVICES, PLLC

Referral Form

Referring Provider: _____

Practice/Clinic: _____

Office Phone #: _____**Fax Office #:** _____

Patient Name: _____

DOB: _____

Contact Person (If under 18 years): _____

Relationship to Patient (if applicable): _____

Phone Number: _____**Email Address:** _____

Primary Insurance: _____**ID #:** _____G**roup #:** _____

Subscriber Name: _____

Subscriber DOB: _____ **Relation to Patient:** _____

Reason for Referral: _____

_____

_____

Current/Active Diagnoses: _____

_____

Type of Testing Requesting & Recommending: _____

_____

By signing this form you are indicating that you are recommending that the patient listed above is being referred for psychological/neuropsychological testing, and that as their provider, are deeming testing to be medically necessary to determine appropriate recommendations and treatment.

_____	_____	_____
Physician's Signature	Printed Name	Date

Completed form can be faxed to NC Center for Counseling & Psychological Services

Fax Number: (919) 573-0869

** If a Prior Authorization is required per insurance, please provide the completed form with referral. The CPT Codes should be listed: 90791 (1 unit), 96136 (1 unit per session), 96137 (7 units), 96132 (1 unit per session), 96133 (6 units).

Thank You For Your Time and For The Referral!