CENTER BASED ABA

Intercept Health

Please complete, save and email this form to:
abareferrals@intercepthealth.com

REFERRAL FORM

Identifying Information	
Date:	
Client Name:	DOB:
Address:	SS#: DND
Parent/Legal Guardian(s):	Parent/Legal Guardian Phone:
Parent/Legal Guardian E-mail:	Parent/Legal Guardian Alt. Phone:
Referral Source:	Referral E-mail:
Insurance Information	
Medicaid MCO:	Toll Free Number (on back of card):
Medicaid Member ID:	Medicaid # (12 digits):
Private Insurance Co. Name:	Toll Free Number (on back of card):
Policy Holder's Name:	Policy Holder Birthdate:
Policy member #:	Policy Group #:
Waiver Information	
Does the individual have the ID/DD waiver? ☐ No ☐ Yes, please provide information below.	
Case Manager Name:	Case Manager Phone Number:
	Case Manager Email:
Diagnosis Information	
Primary Diagnosis:	Secondary Diagnosis:
Reason for Referral: interfering/unsafe behaviors (list and describe), limited communication, social skills, or adaptive living skill deficits (list and describe)	
Current school and services, if applicable:	

Referral for: ☐Center based ABA services ☐ ADOS screening