Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
Fax: 803-714-6456
www.CompanionBenefitAlternatives.com

Initial Outpatient Mental Health Treatment Request Form

CBA will accept a request by fax for initiating certification of outpatient office visits.

NOTE: CBA will not accept referrals for psychological testing on this form. Please contact CBA to request a form for psychological testing services.

**Required information*

Clinician's First Name*: _____ Clinician's Last Name*: _____

Licensure*: _____ Mailing Address 1*: _____

Phone*: _____ Mailing Address 2: _____

Fax*: _____ City*: _____ State*: _____

E-mail: _____ ZIP Code*: _____

Clinician's NPI*: _____ Group NPI: _____

Patient's First Name*: _____ **Patient's Last Name***: _____

Date of Birth*: _____ **ID Card Number*:** _____

Phone: _____ **E-mail:** _____

What Service(s) Are You Requesting*? (check all that apply)

☐ Evaluation ☐ Individual Therapy ☐ Family Therapy

☐ Medication Management ☐ Group Therapy ☐ Marriage Therapy

Certification Start Date*: _____

Please tell us more about the patient's diagnosis or presenting symptoms*:

☐ Diagnosis ☐ Presenting Symptoms

_____

_____

_____

Certification is not valid until CBA issues a certification number.