SALADO CREEK
MENTAL HEALTH

Referral Form

Patient Name_____DOB_____

Phone Number_____

Address_____

Reason for referral: _____

Patient's Insurance

○ Aetna	○ Optum	○ Tricare pending
○ Cigna	○ Oscar	○ BCBS expected to be in network 12/23
○ Humana	○ United	○ private pay
○ Other_____		

Member Policy Number_____

Referring Provider_____

Title_____

Group/Practice/Organization_____

Phone_____Fax_____

Thank you for your referral!

Please fax this form to us at: 210-512-9583

Or please call with questions: 210-405-3008

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