



Family Behavioral Health Referral Form



Part A: Referring Provider (Your Details)

Full Name:

Agency Name (if applicable):

Phone Number:

Fax/Email:

Part B: Potential Client Information

Last Name:

First Name:

M.I.

Date of Birth:

Phone Number:

Part C: Potential Client Insurance Information

Primary Insurance:

Recipient ID #:

Secondary Insurance (if applicable)

Recipient ID #:

Part D: Potential Client's Parent/Guardian Information (if applicable)

Full Name:

Relationship to Client:

Phone Number:

Part E: Reason for Referral

PLEASE SEND THIS FORM BACK TO FAMILY BEHAVIORAL HEALTH VIA MAIL, FAX, OR EMAIL

Family Behavioral Health
438 Pyramid Way
Sparks, NV 89431

Phone: (775) 378-2775
FAX: (775) 525-3889

Email: info@fbhnv.com
www.fbhnv.com