Halcyon Behavioral

# TRANSITION OF CARE REQUEST FORM

**REQUEST SUBMITTED ON (DATE):** _____

## MEMBER INFORMATION

Patient's Name: _____ Date of Birth: _____

Insurance ID #: _____ Telephone: _____

Address: _____

Employee Name: _____ Insurance ID #: _____

Relation to Patient: _____ Telephone: _____

Address: _____

Employer Name: _____

## CURRENT TREATMENT PROVIDER INFORMATION

Provider's Name: _____

Office Phone: _____ Office Fax: _____

Office Address: _____

Services Provided: ☐Therapy ☐Medication Management ☐Other: _____

Date of Next Scheduled Visit (if applicable): _____

How long have you been in treatment with this provider? _____

How frequently are you seen by this provider? ☐Weekly ☐Monthly ☐Other: _____

Provider's Name: _____

Office Phone: _____ Office Fax: _____

Office Address: _____

Services Provided: ☐Therapy ☐Medication Management ☐Other: _____

Date of Next Scheduled Visit (if applicable): _____

How long have you been in treatment with this provider? _____

How frequently are you seen by this provider? ☐Weekly ☐Monthly ☐Other: _____

Sent to Halcyon Behavioral on: _____ ☐Email ☐Fax By (initials): _____

**Mail: Halcyon Behavioral PO Box 25159 Fresno, CA 93729 *or* Fax: (888)304-1429**