PSYCHIATRIC REFERRAL REQUEST FORM

Humana Medicare and Other Referral-Based Plans

Brittany Castillo, PMHNP-BC
NPI: 1033659412
4421 Conlin Street, Suite 101, Metairie, LA 70006
Phone: (985) 264-1876 | Fax: (504) 226-0731 | Secure Email: info@chamberspsychiatricservices.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Insurance Plan: _____ Member ID: _____

Address: _____

Phone Number: _____ Emergency Contact: _____

Relationship: _____ Emergency Phone: _____

PRIMARY CARE PROVIDER INFORMATION

PCP Name: _____ Practice Name: _____

PCP NPI: _____ Phone Number: _____

Fax Number: _____ Date of Referral: _____

REQUESTED PROVIDER

Brittany Castillo, PMHNP-BC | NPI: 1033659412

Requested Services - check all that apply:

- ☐ Psychiatric Diagnostic Evaluation
- ☐ Medication Management
- ☐ Individual Psychotherapy
- ☐ Psychiatric Consultation
- ☐ Other: _____

Requested Number of Visit _____

REASON FOR REFERRAL

Please check all applicable concerns:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ PTSD
- ☐ ADHD
- ☐ Insomnia
- ☐ Dementia / Memory Concerns
- ☐ Behavioral Disturbance
- ☐ Mood Disorder
- ☐ Psychosis
- ☐ Substance Use Disorder
- ☐ Recent Psychiatric Hospitalization
- ☐ Suicidal Ideation History
- ☐ Other: _____

Clinical Summary / Reason for Referral:

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ICD-10 DIAGNOSIS CODE(S)

1. _____

2. _____

3. _____

4. _____

CURRENT PSYCHIATRIC MEDICATIONS

ATTACHMENTS INCLUDED

- ☐ Insurance Card
- ☐ Demographic Sheet
- ☐ Medication List
- ☐ Recent Office Note
- ☐ Hospital Discharge Summary
- ☐ Relevant Laboratory Results
- ☐ Other: _____

PROVIDER ATTESTATION

I certify that the above patient requires psychiatric evaluation and/or treatment and that the requested services are medically necessary.

☐ I certify that the patient has been informed of this referral and that disclosure of information to Brittany Castillo, PMHNP-BC is permitted for treatment purposes.

Provider Signature: _____ Printed Name: _____

Date: _____

SUBMISSION INSTRUCTIONS

Please submit the completed referral form and supporting documentation by one of the following methods:

Fax: (504) 226-0731

Secure HIPAA-Compliant Email: info@chamberspsychiatricservices.com

CONTACT INFORMATION

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IMPORTANT DISCLOSURE

Submission of this referral form does not guarantee appointment availability, acceptance as a patient, insurance authorization, or coverage of services. Additional clinical records or information may be requested prior to scheduling.

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CONFIDENTIALITY NOTICE

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If you have received this document in error, are not the intended recipient, or are not authorized to receive this information, you are hereby notified that any review, use, disclosure, copying, distribution, or reliance upon the contents of this communication is strictly prohibited. Please notify the sender immediately and securely destroy all copies of the document.

By transmitting this referral, the referring provider certifies that the disclosure of information is permitted by applicable law and is for purposes of treatment, payment, healthcare operations, or as otherwise authorized by the patient.

Please fax to (504) 226-0731 or email securely to info@chamberspsychiatricservices.com.