HELPING HANDS
PEDIATRIC THERAPY SERVICES

Referral Form

2049 Richmond Highway
Stafford, VA 22554
PH: 540-657-1424 FAX: 540-657-1423

Requesting for patient to be evaluated for:

_____ **Occupational Therapy** _____ **Speech Therapy**

Reasons for Referral: _____ **Dx Code:** _____
_____ _____

Patient Name: _____ Patient's DOB: ____/____/____
Parent/Caregiver Name: _____ Phone Number: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Has child received therapy services prior to this referral? _____YES _____NO
If yes, when? _____ If yes, where? _____

Helping Hands, Inc. accepts the following insurances: Aetna HMO/PPO, Anthem BCBS, Anthem BCBS Federal Employee Plan, CareFirst BCBS, CHAMP VA, Cigna, Kaiser Permanente, Tricare Standard and Prime, Virginia Premier and Virginia Premier Elite Plus.

Primary Insurance Coverage for Child: _____
ID # _____ Group # _____
Effective Date: _____ 1-800 # from Back of Card: _____
Policy Holder: _____ Policy Holder's DOB: _____ Relation to Patient: _____

Secondary Insurance Coverage for Child: _____
ID # _____ Group # _____
Effective Date: _____ 1-800 # from Back of Card: _____
Policy Holder: _____ Policy Holder's DOB: _____ Relation to Patient: _____

Helping Hands, Inc. will send a copy of the evaluation conclusion and proposed treatment plan to the ordering physician before therapy is initiated. Please be sure to provide us with the following information:
Referring Physician's Name: _____ Date: _____
NPI # _____
Phone Number: _____ Fax Number: _____

Thank you in advance for referring your patient to us. Please note, new patient appointments are typically scheduled 2-3 months from the initial inquiry. If you have questions, please be sure to contact us at 540-657-1423.