Gaines Psychological Services, LLC
209A Mission Street
Madison, AL 35756
Phone: 256-203-4122
Fax: 256-870-2298
drgaines@gainespsych.com
www.gainespsych.com

Clinician Referral Form

Once completed, please email to drgaines@gainespsych.com or Fax to 256-870-2298. Thank you for your referral!

Date: _____

Patient Name: _____ DOB: _____ Phone #: _____

Mailing Address: _____ Email Address: _____

Insurance Company: _____ Contract Number: _____

Referring Clinician: _____

Office Phone #: _____ Fax #: _____

Please list reason for referral:

(For Office Use Only)

Appointments needed: ☐ 1 two-hour ☐ 2 two-hour ☐ 1 one-hour AND 1 two-hour

Effective dates: _____-_____ Covers _____% of allowed amount. Copay / Coinsurance: _____

Deductible applies? Yes / No Individual: _____ met of _____ Family: _____ met of _____

OOP applies? Yes / No Individual: _____ met of _____ Family: _____ met of _____

Referral required? Yes / No Preauthorization required? Yes / No

Exclusions: _____

Insurance Guarantor Name: _____ D.O.B. _____

Insurance Rep Name: _____ Call Ref. #: _____

Entered: ☐