

TOGETHER LINE INITIAL REQUEST FOR OUTPATIENT SERVICES

Please send form to Together@Childrens-specialized.org or fax to 609.991.6145

Please email or fax a separate script for **each** service requested. Each script **must** have:

- | | |
|---|--|
| <ul style="list-style-type: none"> ✓ Date within 6 months ✓ Service Requested ✓ Wording "Evaluation & Treatment" | <ul style="list-style-type: none"> ✓ ICD-10 Diagnosis Code(s) or written reason for referral ✓ Patient's name and DOB ✓ Provider's Name, NPI or License # and Signature |
|---|--|

PATIENT INFORMATION

Name (Last, First, Middle Initial)				
DOB		Gender at birth		
Home Address				
All Services Needed				
Initial Request Date		Scripts sent? _Yes _No		
Primary Location (Check (X) the preferred location)	<input type="checkbox"/> Bayonne	<input type="checkbox"/> Egg Harbor Twp	<input type="checkbox"/> Newark	<input type="checkbox"/> Union
	<input type="checkbox"/> Clifton	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Springfield	<input type="checkbox"/> West Orange
	<input type="checkbox"/> East Brunswick	<input type="checkbox"/> Monmouth	<input type="checkbox"/> Toms River	
Secondary Locations (Check (X) all other locations to which family is willing to travel)	<input type="checkbox"/> Bayonne	<input type="checkbox"/> Egg Harbor Twp	<input type="checkbox"/> Newark	<input type="checkbox"/> Union
	<input type="checkbox"/> Clifton	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Springfield	<input type="checkbox"/> West Orange
	<input type="checkbox"/> East Brunswick	<input type="checkbox"/> Monmouth	<input type="checkbox"/> Toms River	

REFERRING PROVIDER INFORMATION

Name			
Phone #		Fax #	
Office Name			
Office Address			
EMR Used			

REQUESTER INFORMATION (if different than Referring Provider)

Name		Phone Number	
CONTACT INFORMATION	CAREGIVER 1	CAREGIVER 2	
Name			
Relationship to patient			
Phone number(s)			
Email			
Language if not English			
INSURANCE	PRIMARY	SECONDARY	
Insurance Carrier			
Policy #			
Group #			
Policy Holder's Name			
Policy Holder's DOB			

ADDITIONAL INFORMATION

