SPEECH THERAPY PLUS, INC.
"FOCUSED ON THE CLIENT'S INDIVIDUAL NEEDS"
Kayse F. Henry MS, CCC-SLP
Phone: 252-633-6770 Fax: 877-335-6220
speechtherapyplus@gmail.com

REFERRAL INFORMATION FORM

PLEASE CHECK THE TYPE OF HEALTH INSURANCE

☐ **MEDICAID** ☐ **NC HEALTH CHOICE** ☐ **TRICARE STANDARD** ☐ **TRICARE PRIME**

******PLEASE NOTE FOR ALL TRICARE INITIAL REFERRALS*****
THE PCM MUST SUBMIT AN AUTHORIZATION TO TRICARE FOR
SPEECH THERAPY PLUS, INC GROUP NPI # 1679634083 TAX ID # 20-0034364

Child's Full Name: _____DOB_____/_____/_____

Address: _____

Child's Medicaid #: _____

If the child does not have Medicaid or has Medicaid and another Primary insurance

List Primary Insurance #: _____

Company: _____

Company Phone #: _____

List Child's Significant Medical History/ Hearing Screens and Evaluations

IF POSSIBLE PROVIDE COPIES OF EVALUATIONS OR HEALTH INFORMATION

_____

_____

Parent/Guardian's Name: _____

Phone#: _____Work#: _____

Referral Person/Source: _____

EMAIL ADDRESS: _____

Reason for Referral: _____

Child's Primary Doctor/Pediatrician's Information

OFFICE /NAME: _____

Where will the child be seen? ____Home ___Day Care ___Head Start ____Other

Name of Day Care/ Head Start/Other: _____

Contact Person: _____ Phone #: _____

ADDITIONAL COMMENTS OR NOTES:

FAX REFERRAL TO: 877-335-6220