

PHYSICIAN REFERRAL SHEET

Name:

Address:

Phone:

Email:

Certifications or Licenses:

Please list:

Insurance Coverage in Which You Participate:

- | | |
|---|---|
| <input type="checkbox"/> Do not accept 3rd party payments | <input type="checkbox"/> Medicare Plan 65 |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Cigna |
| <input type="checkbox"/> Blue Chip | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> United | <input type="checkbox"/> Aetna |
| <input type="checkbox"/> Travelers | <input type="checkbox"/> Other <input type="text"/> |
| <input type="checkbox"/> Medicare Plan 65 | |

Languages Spoken Other than English

- | | | |
|----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Other <input type="text"/> |
|----------------------------------|-------------------------------------|---|

Specialty Areas:

- | | |
|---|---|
| <input type="checkbox"/> Substance Abuse (Alcohol & Drug) | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Co-Occurring Disorders |
| <input type="checkbox"/> Children/Adolescents | <input type="checkbox"/> Other <input type="text"/> |

I agree to have my name and the information listed above posted on the RIBCCDP website and other related websites for the purpose of informing medical professionals of my interest and ability to treat clients who have substance abuse disorders and their families.

Signature

Date

Printed name

PLEASE COMPLETE AND RETURN FORM BY MAY 15, 2010

Email to ricert@msn.com

FAX to 349-3833

Send to: RIBCCDP 31 Smith Ave – 3 Rear, Greenville, RI 02828