Fax: 803-714-6456 cba@companiongroup.com Voice: 800-868-1032

Companion Benefit Alternatives, Inc.

Outpatient Treatment Initiation Form

Requestor's Name & Phone #_____

Provider's NPI# _____ Group NPI# _____

CBA will accept a request by facsimile for initiating certification of outpatient office visits.

NOTE: CBA will not accept referrals for psychological testing on this form. Please contact CBA to request a form for psychological testing services.

Your Name: _____

Your Office Fax #: _____

Please provide the following information below:

Patient's Name: _____ ID Card #: _____

Referred By: _____ Patient's DOB: _____

Provider to See Patient: _____

Address Where Service will be Rendered: _____

_____

What service are you requesting (check all that apply)?

☐Med Mgmt ☐ Individual ☐Group ☐ Family ☐Marriage

Diagnosis: _____ CPT4 code: _____

Presenting Symptoms: _____

_____

Treatment History: _____

Medications: _____

How many visits are you requesting? _____

Length of treatment requested? _____

When is patient's first appointment? _____

Certification is not valid until a certification # is received from CBA.

Please make additional copies of this form for your office use. Thank you.