Southeastern Center For Behavioral Health

Commercial BCBS - Medicaid
712 Calhoun Street, Suite B, Columbia, SC 29201
admin@secbh.org | Fax: 803-369-6109

Date: _____

CLIENT INFORMATION

Client Name: _____ **DOB:** _____

Parent Name: _____ **Phone** _____

Required Client Email: _____

Insurance: ☐ Commercial BCBS ☐ Medicaid

Plan ID #: _____

PROVIDER INFORMATION

Referring Provider Name: _____ **NPI:** _____

Medicaid Referral/Auth #: _____

Practice Name: _____

Referral Contact Name: _____ **Contact Email:** _____

Direct Phone #: _____ **Fax:** _____

REFERRAL DETAILS

Reason for Referral: ☐ Testing/Assessment ☐ Therapy

Referring Diagnosis: Please include ICD-10 code and any medication prescribed for this condition.

PLEASE DO NOT SEND RECORDS - RETURN THIS SHEET AND DEMOGRAPHICS ONLY