

UCP-CM No Boundaries Assistive Technology Center

REFERRAL FORM

(Please Print)

Today's date:			Person Making Referral:			
PATIENT INFORMATION						
Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Diagnosis:	Date of Diagnosis: / /	Email address:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone #: ()	
City:		State:		ZIP Code:	Alternate Phone #:	
Occupation:		Employer:			Employer phone no.: ()	
Place of Residence:						
<input type="checkbox"/> Home		<input type="checkbox"/> Nursing Home		<input type="checkbox"/> In-home Hospice Care		
<input type="checkbox"/> Assisted Living Facility		<input type="checkbox"/> Group Home		<input type="checkbox"/> Rehabilitation Facility		
<input type="checkbox"/> Hospital		<input type="checkbox"/> Hospice				
REASON FOR REFERRAL						
Name of Person Making Referral:		Relationship to Patient:	Address (if different):		Phone no.: ()	
Type of Referral: <input type="checkbox"/> Communication Assessment <input type="checkbox"/> Communication Therapy – Name of device: _____						
<input type="checkbox"/> Computer Access Assessment <input type="checkbox"/> Computer Access Training – Name of Products: _____						
<input type="checkbox"/> Speech & Language Assessment <input type="checkbox"/> Speech & Language Therapy						
Please describe reason for assessment/therapy:						
Patient is unable to: <input type="checkbox"/> Talk <input type="checkbox"/> Talk Clearly <input type="checkbox"/> Read/Spell <input type="checkbox"/> Handwrite <input type="checkbox"/> Walk <input type="checkbox"/> Use Hands <input type="checkbox"/> Identify Pictures						
PHYSICIAN INFORMATION						
Name of Primary Care Physician:						
Street address:			Suite #:		Phone #:	
City:		State:		ZIP Code:	Fax #:	
UPIN #:		NPI #:		Medical Assistance 9 digit Provider #:		

INSURANCE INFORMATION

Please note: UCP-CM No Boundaries Assistive Technology Center does not accept Insurance, Medicare, or Medical Assistance as forms of payment for assessments, therapy, or training. Information below should be completed for Patients receiving a Communication Device Assessment to assist in procurement of the communication device:

Is this patient covered by insurance? Yes No

Please indicate primary insurance

Insurance Name of Company: _____
 Medicare
 Medical Assistance
 Managed Care Organization: Name of Company: _____
 Other: _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: ____/____/____ Group no.: _____ Policy no.: _____ Co-payment: _____ \$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child

**** If patient is receiving an assessment for a Communication device, please provide a copy of the front and back of the patient's insurance cards to UCP Staff on the day of the assessment****

Other

PAYMENT INFORMATION

Method of Payment for assessment/therapy/training: Check Cash

FEE SCHEDULE

Fees for services are listed below. Payment may be made on the day of service or, for your convenience, an invoice can be mailed following provision of services:

Pay on day of service Please invoice

Fees:

Augmentative and Alternative Communication Assessment	\$300.00
Assistive Technology/Computer Access Assessment	\$300.00
Speech & Language Assessment	\$200.00
Augmentative and Alternative Communication Set-up/Therapy/Training	\$80.00 per hour
Assistive Technology/Computer Access Set-up/Therapy/Training	\$80.00 per hour
Speech & Language Therapy	\$70.00 per hour
Travel fees for any service occurring outside of UCP's main office:	\$35.00 per hour

Interested in: Office Appointment In-home appointment

Please return this completed form to UCP-CM No Boundaries Assistive Technology Center by:

Mail: UCP-CM No Boundaries Assistive Technology Center
 Executive Plaza III
 11350 McCormick Road
 Suite 1100
 Hunt Valley, MD 21031
 410-484-4540 ext. 2580

Fax: 410-771-3236 Attn: Angela Strauch

Email: astrauch@ucp-cm.org

Once your referral form has been completed, you will be contacted to schedule an appointment. Thank you.

