

Please print and fax this sheet with your information to (818) 996-0260

AllCare Behavioral Health Services, Inc.
PO Box 1700
Encino, Ca 91416-7000

Date of referral _____ Telephone # _____

Patient's Name _____

DOB _____ M _____ F _____

Address _____

Caretaker's Name & Relationship (for minors only): _____

I am seeking services for: Psychiatry (medication evaluation)
 Psychology (therapy)
 Gastric bypass assessment
 Other: _____

Insurance: _____ HMO PPO Other

Subscriber's Name: _____ DOB: _____

Member ID #: _____ Group #: _____

Customer Service # for Insurance plan: _____

Medi-Cal # (if applicable) _____

Comments:

I heard about AllCare through: _____
