Premiere Transitional Services Inc.

Building Healthy Families One Transitional Step At A Time

CLIENT REFERRAL FORM

3330 Cumberland Blvd.
Suite 500 | Atlanta, GA 30339
P: 678-638-6610
F: 1-888-662-5262

44 Darby's Crossing Drive
Suite 110 D | Hiram, GA 30141
P: 678-383-6438

Referral Date _____

Referral (Consumer)

Consumer Name:_____

Date of Birth:_____/_____/_____

Address:_____

City_____State_____Zip_____

Phone: (_____)_____-_____ Alternate #: (_____)_____-_____

Email Address: _____@_____._____

Parent/Guardian:_____

Insurance Type

Accepted Insurances:
Accepted Insurances: Medicaid, Peachstate, Amerigroup and CareSource for IFI and CORE services Blue Cross/Blue Shield for Psychiatric Only.

Check All that apply

- ❍ HMO (Health Maintenance Organizations)
- ❍ PPO (Preferred Provider Organizations)
- ❍ HSA (Health Savings Accounts)
- ❍ Medicaid
- ❍ Other _____

Medicaid Number: _____

Insurance Name:_____

Insurance Number:_____

Consumer ID Number (CID):_____

Referral Source

Referral Phone/Fax

Referral Email

Reason for Referral

❍ PLEASE CHECK If a Monthly Report is Required

PTSI Referral Form 2017