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HappyHearts ABA

Provider Referral Form

Unlock Your Patient's Potential with Rapid Access to ABA Therapy

Thank you for referring your patient to Happy Hearts ABA for ABA Therapy. Please fill out the following information and submit it via fax or email. If possible, please also attach the Supporting Documentation listed below if available. Our Intake Specialist will call you to confirm receipt of this referral within 24 hours.

REFERRING PROVIDER INFORMATION

Date of Referral: ______________________________

Provider Name: ______________________________

Phone Number: ______________________________ Email: ______________________________

Provider Type: ☐ Diagnosing Provider ☐ PCP/Pediatrician ☐ Other

PARENT / CHILD INFORMATION

Child Name: ______________________________ Date of Birth: ______________________________

Guardian/Parent Name: ______________________________

Phone Number: ______________________________ Email: ______________________________

Reason for Referral: ______________________________

Autism Diagnosis: ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Plan: ______________________________

SUPPORTING DOCUMENTATION

☐ The patient's comprehensive diagnostic evaluation (if available).

☐ A referral for therapy that includes a diagnosis code for Autism Spectrum Disorders (F84.0).