



LOWELL
TREATMENT
CENTER

A Program Of Arbour Health System

Community Services

Lowell Treatment Center
391 Varnum Avenue, 2nd floor • Lowell, MA 01854
Phone: 800.727.6324 • Fax: 978.322.5097

Please send referrals via FAX to: (978) 322-5097

For **Family Stabilization Team/In-Home Therapy**, we accept the following insurances:
MBHP, Network Health, BMC HealthNet, NHP, Fallon, BCBS, United/HPHC, Tufts, and Cigna.
. For BCBS, UBH/HPHC, Tufts, and Cigna, the referrer must obtain prior authorization before services can begin.

For **Community Support Program**, we accept the following insurances:
MBHP, Network Health, BMC HealthNet, NHP, Fallon

For **Therapeutic Mentoring**, we accept the following insurances:
MBHP, Network Health, BMC HealthNet, NHP, Fallon
Referrer must be child's Outpatient Therapist, In-Home Therapy Clinician, or Intensive Care Coordinator
Please fax a copy of youth's individual treatment plan identifying the goal for treatment.

This a referral for (check one)

FST/In-Home Therapy Community Support Program (CSP) Therapeutic Mentoring

Authorization Information

Authorized dates of service _____ # Units authorized _____

Authorization # _____

Client's name _____ M ____ F ____ DOB _____ Age _____

Insurance (Payer) _____

Policy ID# _____ Social Security # _____

Address _____ Zip: _____

Phone _____ Alternate phone _____

Guardian's name(s) _____ Relationship to client _____

Does the client or guardian speak English? _____ If not, preferred language _____

Referring agency _____ Person referring _____

Phone _____ Fax _____ e-mail _____

Agency involvement (include name, agency, phone)

Therapist _____

Med Prescriber _____

PCC _____

School Contact _____

DCF / DMH / DDS _____

Court _____

Other _____

Other _____

Current medications with dosages

Current diagnosis if known (please include DSM-IV code)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V CGAF _____ HGAF _____

Has the family agreed to services? ___Y ___N

Are there any outstanding 51As with DCF or does the home environment pose a safety risk?

___Y ___N If Yes, Explain _____

Signature of Referring Provider _____ Date _____

Thank you for the referral.