Optimae Behavioral Health Services

Customer Demographic

Service (Check all that apply): ☐ **Therapy** ☐ **Med Management**

Client Name: **Date:**

Address: **City:** **State:** **ZIP:**

Home/Cell Phone: **May we leave a message?** ☐ **Yes** ☐ **No**

Email:

Date of Birth: **Social Security #:**

Legal Gender: **Preferred Gender Identity/Expression:**

Primary Language: **Interpreter Needed?** ☐ **Yes** ☐ **No**

Parent/Guardian (if applicable): **Phone:**

Address: **City:** **State:** **Zip:**

Emergency/Alternate Contact: **Phone:**

Do you have Medicaid Services: ☐ **Yes** ☐ **No** **Medicaid #:**

MCO: ☐ **Wellpoint** ☐ **Iowa Total Care** ☐ **Molina** **MCO ID #:**

Primary Insurance Information:

Insurance Company: **Insurance ID#:**

Policyholder's Name: **Relationship to Customer:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Policyholder's Date of Birth: **Social Security #:**

Address: **City:** **State:** **ZIP:**

Policyholder's Home/Cell Phone: **Policyholder's Employer:**

Is Policyholder Responsible for Payment of this bill: ☐ **Yes** ☐ **No**

If No, please give Name & Address of Responsible Person:

Secondary Insurance Information:

Do you have secondary policy: ☐ **Yes** ☐ **No** **If Yes, Insurance Company:**

How would you rate the urgency of your need on a scale of 1 – 10 (1 = no urgency, 10 = high urgency):

Are services needed due to a court committal? ☐ **Yes** ☐ **No**

Additional information you would like to share:

Please email referral form to BHreferral@optimaelifeservices.com