EXTERNAL PROVIDER REFERRAL REQUEST

Email to: referrals@azcfc.com or fax to 602-253-8488

Referring Provider Information:

Provider Name: **Referral Date:**

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

Provider Phone # **Provider Fax#**

Contact Person: **Supervisor:**

Member/Client Information:

Name: **DOB** **Member ID#**

Insurance Plan: **Insurance Phone#**

Guardian Information: **Guardian Phone if Different:**

Address: **City** **State** **Zip** **Telephone #**

Diagnosis:

Medications:

Program/Service Requested:

Program/Service Requested:

Why does this person need this service?

AZCFC Use Only

Referral Accepted: ☐ **Yes** ☐ **No**

Reason for Decline:

Date_____