

**REFERRAL FOR**

**LICENSED INDEPENDENT PRACTITIONER SERVICES (LIPS)**

**ONLY TO BE USED BY THE PHYSICIAN FOR SERVICES NOT REQUIRED TO**

**BE LISTED ON THE INDIVIDUAL PLAN OF CARE**

Beneficiary Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Beneficiary Medicaid ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practitioner NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Requested service for referral (check item):** | | **Number of Units Billed** |
| □ | Crisis Management (H2011) in 15-minute increments |  |
| □ | Behavioral Health Screening (H0002) in 15-minute increments |  |
| □ | Psychological Evaluation and Testing (96101) in 60 minutes increments |  |
| □ | Diagnostic Assessment – Initial Comprehensive (H2000) per encounter |  |

**Reason for referral (check item):**

□ An emergency situation/crisis □ Information to assist with determining Medical Necessity

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(****Please print****)*

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEND REQUESTS TO:** KePRO

**FAX (855-300-0082), PHONE (855-326-5219) OR VIA WEB PORTAL (http://scdhhs.kepro.com)**

**SEND A COPY/FAX TO THE LIP**

**DHHS Form LIPS (06/2012)**