Theraplay
Pediatric Services, Inc

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fax 404.355.6814
Theraplay.PT@gmail.com

PATIENT INFORMATION

Referral Source_____ Date of Referral _____
Child's Name _____ Date of Birth_____
Caregiver's Name _____
Address_____
Phone Number (H) _____(W) _____(C)_____
Email/Alternate Contact Info _____
Diagnosis _____
Diagnosis Code(s) 1) _____ 2) _____ 3) _____
Referring Physician _____GBHC # _____
Physician Address _____
Physician Phone _____ Physician Fax _____

BILLING INFORMATION

Insurance Company _____ Eff/Term Date _____
Claims Address _____
Phone Number _____ Fax Number _____
Sub ID _____ Guarantor _____
Guarantor ID _____
Policy/Group Number _____
Guarantor Employer _____
Insurance Plan Name _____
Benefits: Deductible _____ % _____ Maximums ($/visits) _____

Medicaid/Peachcare Number _____

Babies Can't Wait: County _____ Cost Participation _____

Please provide a copy (front and back) of Medicaid and/or Insurance cards. Thank You!