

**Mental Health Services Request**  
**Aspen Valley Medical Foundation-Dr. Jonathan Birnkrant, MD**

*Please follow all the steps below to receive services for your patient.*  
*Requests must be made by completing this form and faxing it to AVMF at 544-1562 for approval.*

Referring Agent Name: \_\_\_\_\_ Agency( if applicable): \_\_\_\_\_

Referring Agent Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient/Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Other contact info: \_\_\_\_\_

Name of primary care physician (required): \_\_\_\_\_ Phone: \_\_\_\_\_

Name of current therapist (optional): \_\_\_\_\_ Phone: \_\_\_\_\_

*I give my permission to send a request to AVMF. I understand that my clinical information will be shared with AVMF and with Dr. Birnkrant.* (required)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**STEP 1: Request for Services:** Pre-approved referral agents can make requests on behalf of clients who are uninsured or underinsured, and have serious financial challenges.

**a. Chief Complaint:** \_\_\_\_\_

**Brief History:** \_\_\_\_\_

**b. Assistance Requested for:**

Therapy      Psychiatric Assessment (evaluation for diagnosis and medication management)

**STEP 2: Financial Need of Client:** Referring agents determine the client's need before requesting assistance.

**a. Qualification (check the appropriate box):**

No Insurance      Underinsured: Medicare    Medicaid

**Disqualified:** Insurance

**b. Financial Need - Proof of financial need indicating self pay is not possible:**

**c. Amount client can pay per visit:** \$20 \$40 \$75 \$100 Other \$ \_\_\_\_\_

**STEP 3: Approval** – Fax form to AVMF, 970/544-1562 and AWAIT return indicating *Approval* or *Denial*. Approval will be faxed back to the referring agency and to Dr. Birnkrant before services are provided.

**STEP 4: Referring Agent Contact** – Referring agent/therapist/physician must contact Dr. Birnkrant AFTER approval received to discuss the case and reason for referral. Call 970/300-1845.

**STEP 5: Appointment** – AFTER the case is discussed between Dr. Birnkrant and the referring agent, have the patient contact Dr. Birnkrant's office to set up an appointment. Call 970/300-1845.

**For AVMF use only**

APPROVED

DENIED

Signature: \_\_\_\_\_ Date: \_\_\_\_\_