Minnesota CarePartner
ROOTS RECOVERY

REFERRAL FORM - ADULT

This referral is for: ☐ Rule 25/Comp Assessment ☐ SUD IOP Treatment ☐ RootsREACH

Referent Information:

First Name:		**Last Name:**	
Company:		**Email:**	
Phone:		**Fax:**	
Relationship to the Client			

Client Information:

First Name:		**Middle:**		**Last Name:**	
Date of Birth:		**Social Security #**			
Reside on Reservation? ☒ Yes ☐ No **Which:**			**Eligible for Indian Health Services?** ☐ Yes ☐ No		
Gender Identity:			**Preferred Pronouns:**		
Sexual Orientation:			**Living Situation:**		
Address:		**City**		**State**	**Zip**
Phone:		**Message ok?** ☐ Yes ☐ No	**Email:**		
Preferred Method of Contact: ☐ Phone Call ☐ Text ☐ Email			**Best Time to Contact:**		
Reason for Referral:					
Primary Concerns:					
Substances Used:					
Currently Receiving Medication Assisted Treatment? ☐ Yes ☐ No			**Clinic?:**		
Mental Health Diagnoses/Concerns:					
Current Therapy/Treatment Services & Supports					

Funding/Payment Information:

What is the planned payment method for services? ☐ Self-Pay ☐ Insurance ☐ Other:					
Client Insurance? ☐ Yes ☐ No	**Type:** ☐ Commercial ☐ PMAP ☐ MA/Medicaid			**PMI #:**	
Insurance Carrier:	☐ Ucare ☐ Medica	☐ Medicaid/MA/PMAP ☐ Health Partners	☐ Preferred One ☐ BlueCross	☐ Henepin Health ☐ Other	
Policy Holder: ☐ Client ☐ Parent/Guardian ☐ Spouse/Other			**Name:**		
Policy Number:		**Group Number:**		**Prior Auth Needed?** ☐ Yes ☐ No	

You may submit this form to:

email: roots@mncarepartner.com **fax:** 612.564.5932 **web:** www.mncarepartner.com/referral