McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Ambulatory Treatment Center at Naukeag
211 North Main Street
Petersham, MA 01366
800.230.8764
Fax: 978.756.5150

Dear Provider,

Thank you for your interest in the Ambulatory Treatment Center at Naukeag. We have tried to keep the admission process simple. There are two forms to fill out (B and C) that need to be faxed to us, and one form (Form A) a checklist of material required for admission. We suggest that you make copies of these forms so that referrals can be made without having to request the packet from us in the future.

For more information or with any questions, call us at **978.756.5100.**

Referral Process

1. Determine if the patient has been to Naukeag before, if so call Naukeag to determine the patients readmit status.
2. Determine if the patient **meets all of the admission criteria. (a-g below)**

   a) The applicant has completed his/her detox from substances (no detox medications day of admission) and is not prescribed any addictive medication. e.g. benzodiazepines, Ambien, narcotics, Ultram, Soma. (Call if unsure of a medication).

   b) The applicant is medically stable and cleared for ambulatory level of care.

   c) The applicant is cognitively capable of participating and benefiting from the treatment milieu of 5 groups per day and an off site self-help meeting.

   d) The applicant is able to hold and self-administer medication, handle self-care and function independently in an open milieu.

   e) The applicant is psychiatrically stable to live in an independent setting. The applicant's psychiatric problem will not interfere with the milieu of the program.

   f) The applicant is 18 years or older.

   g) The applicant can pay; the night fee (if required), and co-pays on medication (fees can be discussed at time of phone interview).

3. Fill out the top of (**Form A)** and check off each item as you collect it. If an item is to be sent later note this on the fax cover sheet.
4. Complete the demographic/insurance form **(Form B)**
5. Fill out pharmacy registration form **(Form C).** Make **copies of front and back of prescription card**
6. Fax the packet to Naukeag (a fax cover sheet is included for you to use). Write any comments on the fax cover sheet

FORM A

Ambulatory Treatment Center at Naukeag Referral Checklist

Fill out top of form, and then gather necessary information and fax to 978.756.5150

Applicant Name: ______________________________________ Date: _____________________

Hospital/Program: _________________________________ City: ________________________

Person making referral: _____________________________ Phone: ______________________

Phone number to call to set up patient interview: __________________________________

REQUIRED AT ADMISSION

- ☐ Must present a photo ID
- ☐ Must have Prescription Card

TWO FORMS TO BE COMPLETED AND FAXED WITH PACKET (FORMS B, C)

- ☐ Completed demographic /insurance form. **(Form B)**
- ☐ Pharmacy Registration Form **(Form C)** **(Patient must have pharmacy card at admission)**

INFORMATION FROM RECORDS THAT NEED TO BE FAXED WITH PACKET

- ☐ Psychosocial History (typed or legibly written)
- ☐ Physical Exam – signed by MD
- ☐ Lab/Test Results
- ☐ Medication List
- ☐ TB (PPD) results or TB screening form

FORM B

Ambulatory Treatment Center at Naukeag Demographic Insurance Form

Applicant Name: ______________________________ DOB: ________________________

Address: ____

Applicant Phone: ______________________ cell phone Y N

Referred By: ________________________ Phone: ______________________________

Hospital: ___________________________ City, State: ____________________________

Has the applicant been to Naukeag Before? N Y Date: ___________________________

INSURANCE INFORMATION

Medicare/Medicaid Tufts Harvard Pilgrim BC\BS UBH/HPHC UBH/United Healthcare

Other: _______________________________________

Subscriber Name if different from Applicant: ______________________________________

Subscriber DOB: ____________________

Insurance I.D. #: _____________________ RID #:_______________________________

Policy # ___________________________ Group #: _______________________

Insurance Co 800 # for MH/SA (usually on reverse side of card):__________________________

McLean Use Only

Medicare/Medicaid Active Y N Any supplemental insurance Y N

Precert Required? Y N Phone #: ______________________________________

Benefits: Partial Residential Night Fee

Comments:____

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Date/Time Sent: _________________________ **Staff Initials:** _________

FORM C

Ambulatory Treatment Center at Naukeag Pharmacy Form

Please PRINT CLEARLY, fill out form completely and FAX to 978.756.5150

Any questions please call 978.756.5100

Last Name: __________________________ **First Name:** ____________________ **MI:** ______

Sex: **Male** **Female** **DOB:** _________________________

Mailing Address ___________________________________ **City:** _________________________

State: _____ **Zip Code:** ____________ **Telephone: #** ________________________________

Medication Allergies: ____

Insurance Information

Fax LEGIBLE copies of pharmacy card FRONT AND BACK. The pharmacy cannot fill RX's without a copy of the prescription card.

No Insurance (self-pay)

Medicare/Mass Health

Private Insurance (if checked please fill out information below)

Plan _____________________________________ **BIN#** ___________________________

ID# ______________________________________ **RX Group #:** ________________________

Subscriber's Name: ____

Method of Payment

☐ **Cash** ☐ **Credit Card**

I hereby allow the disclosures of all information above to Athol Pharmacy.

Signature of Applicant ___________________________________ **Date:** _________________

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Ambulatory Treatment Center at Naukeag
211 North Main Street
Petersham, MA 01366
Tel: 978.756.5100 fax: 978.756.5150

ADMISSION FAX TRANSMISSION

To: Naukeag Admissions		From:
Phone: 978.756.5100		Phone:
Fax: 978.756.5150		Fax:
Date:	Total # of pages: (Including cover)	

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply

MATERIAL FAXED: Admission Packet and required documentation.

COMMENTS:	

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