RECOVERY TECHNOLOGY L.L.C.

Clinician Transfer

Date: _____

Client Name: _____ **Case Number:** _____

Effective Date of Transfer: _____

Reason for Transfer:

Transferring Clinician: _____	**Receiving Clinician:** _____
☐ Data Errors	☐ Verified
☐ Community Physician Coordination	☐ Verified
☐ Current PCP with all signatures	☐ Verified
☐ Formal Reviews/Quarterlies complete	☐ Verified
☐ Current Psychosocial	☐ Verified
☐ Current Fee	☐ Verified
☐ Current Consents/Releases	☐ Verified
☐ Medicaid/Non-Medicaid Hearing Rights	☐ Verified
☐ Home/Guardian notified (If applicable)	☐ Verified
☐ Authorizations up to date	☐ Verified
☐ Crisis Plan	☐ Verified
☐ Current DLA	☐ Verified

Program Manager Signature: _____

Billing Department Signature: _____