

STAR East

STAR Central

STAR West

STAR-Stand Together And Recover Centers Recipient's Name: _____
1014 N 24th St. #11
Phoenix, Arizona 85008 Date of Birth: _____
(602) 685-1295 (602) 231-0334 FAX

**S.T.A.R. – Stand Together And Recover Centers
REFERRAL REQUEST FORM**

Service Recipients who either refer themselves to STAR or are referred by Magellan clinics or other providers must submit a STAR Referral Request Form. The STAR Referral Request Form must be approved by STAR administration prior to the member's attendance. It is therefore the responsibility of the provider staff (case manager, etc.) that refers service recipients to submit this completed Request Form to STAR.

The STAR Referral Request Form must be forwarded to STAR in advance and approved by STAR prior to the service recipient's attendance, and must include the following items:

- 1) *This request, with required signatures.*
- 2) *Current service recipient's signed Diagnosis, Assessment (Part E), and ISP.*
- 3) *Does the recipient have AHCCCS coverage including behavioral health benefits? Please mark appropriate box below:*

Yes

No

Does the service recipient have any SOCIAL BEHAVIORS that may require additional attention from STAR staff? Yes No

If yes, please explain: _____

I verify that this service recipient's attendance at STAR is part of his/her current ISP.

Case Manager's Signature

Date

Sign here only if the check box under line 3 is marked "Yes."

I verify that _____ is Title XIX eligible.

Case Manager's Signature

Date