Acentra HEALTH

Behavioral Health Member Choice Form

Member Name: _____

Date of Birth: _____

Medicaid Number: _____

Member ID: _____

I, _____ choose to receive _____
(Member/Legal Representatives Name) (Type of Service)

(for example, individual therapy or family therapy) from _____
(Provider Requesting Authorization)

effective ___/___/___. I understand that only one provider may be authorized to provide a specific therapeutic service to me at a time. I further understand that my choice is voluntary and that the authorization for services may be transferred to another provider at my request.

_____ _____
Member/Legal Representative Date

_____ _____
Witness Date

1007 Bullitt Street, Suite 200 * Charleston, WV 25301 * 304-346-6732 * Fax: 866-473-2354