Preferred care
It's time to live well

Preferred Care Timothy's Law Request Form

Date _____

Provider Name _____

Member Name _____

Contract # _____

Number of Visits Requested _____

Diagnosis
Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Please outline treatment direction and the anticipated timeframe for resolution of the clinical condition(s) that is(are) being treated.

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Provider Signature _____

Please fax to the Behavioral Health Dept. at 585-454-1446.

Please call the Behavioral Health Dept. with any questions at 585-258-8077. Thank you.