Texas Referral/Authorization Form

Please fill out form completely in blue or black ink. Refer to instruction sheet.

This referral does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits.

❑ CHIP ❑ STAR/Medicaid ❑ OTHER_____

❑ ROUTINE ❑ URGENT
❑ EMERGENCY
❑ OUT OF NETWORK
❑ REVISED REFERRAL
❑ NOTIFICATION ONLY

HEALTH PLAN NAME: ___________________________ DATE ____/____/____
Health Plan Fax# 1-866-741-5650

PATIENT INFO.

Patient name ____
LAST FIRST MIDDLE INITIAL

DOB ______/________/______ Sex M❑ F❑ Phone # (____)____________________

Member ID #____________________ Member Social Sec. # ______-_________-________
OPTIONAL

REFERRED BY

Physician name ____
LAST FIRST M.I.

Provider # ______________________________ ❑ PCP ❑ SCP ❑ HOSPITAL

Fax # (______)____________________

Contact name ________________________ Phone # (_____)_________________

REFERRED TO

Provider name ____
LAST FIRST M.I.

Specialty type _________________________ Provider/Facility # ________________

Fax # (_____)____________________ Phone # (_____)______________________

Provider City __________________________, Texas

REFERRED TO LOCATION

❑ Office ❑ Outpatient facility*** ❑ Inpatient ❑ 23 Hour observation
***Note for outpatient facility, List CPT4 at right
❑ ER/Post Stabilization ❑ Other Date of service _______/________/______

Facility name ____

Facility # * ___________________________ * Required for ER/UCC, Therapy and Outpatient services.

COMMENTS/CLINICAL HISTORY ______________________________________

____

____

____

Clinical information attached: ❑ Y / N ❑ # of pages _____

PHYSICIAN SIGNATURE- ____

The information contained in this form is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Requested Start date ____/_______/_______
Requested End date _____/_______/_______

ICD-9/DSM4/Diagnosis_________
____

Scope of referral

❑ Consultation
❑ Diagnostic Testing
❑ Follow-up
Number of visits _____

SPECIFIC SERVICES REQUESTED**

**Refer to specific plan instructions.
Certification/authorization guidelines must be followed.

❑ Behavioral Health
❑ Dialysis
❑ DME/Prosthesis/Supplies
❑ Case Mgmt. ____________________
____
❑ Health Educ. __________________
____
❑ Home Care
❑ Injections and IV Therapy
❑ Maternity Services:
EDC ________________________
❑ Vaginal ❑ C-Section
❑ Lab/Pathology
❑ Radiology/ Imaging
❑ Therapy: Indicate # of visits _______
❑ Physical ❑ Cardiac Rehab
❑ Speech ❑ Occupational
Visits/Week _____
❑ Surgery ____________(CPT4 code)
❑ Assistant Surgeon

TO AUTHORIZE ONLY (OR OTHER) SPECIFIC SERVICES, INCLUDE CPT4 /MEDICAID LOCAL OR HCPCS CODES HERE.

____________ ____________
____________ ____________
____________ ____________

HEALTH SERVICES RESPONSE

❑ Approved as requested Authorization # __________________
Expiration date ______/______/______
Days authorized _____

❑ Medical Director Review ❑ Pending Info. ❑ No referral needed ❑ Denied ❑ Approved with modification

NOTES ____Signature ___________________________Date: ___/___/_____

Revised 12-15-00