

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 EPO HMO PCCM POS PPO W/C OTHER _____

ROUTINE URGENT
 EMERGENCY
 OUT OF NETWORK
 REVISED REFERRAL
 NOTIFICATION ONLY

HEALTH PLAN NAME: _____ DATE ____/____/____
Health Plan Fax# (____) _____

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-

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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: ____/____/____

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.

