CFHP Health Services
Fax Number:
210-358-6040 or
1-800-887-7974

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

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

ICD-9/DSM4/Diagnosis_____
_____

Scope of referral

Consultation
Diagnostic Testing
Follow-up
Number of visits _____

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.

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

Exhibit 7