

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 _____

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

PATIENT INFO.

Patient name _____
DOB ____/____/____ Sex M F Phone # (____) _____
Member ID # _____ Member Social Sec. # _____ - _____ - _____
OPTIONAL

REFERRED BY

Physician name _____
Provider # _____ PCP SCP HOSPITAL

Fax # (____) _____

Contact name _____ Phone # (____) _____

REFERRED TO

Provider name _____
Specialty type _____ Provider/Facility # _____

Fax # (____) _____ Phone # (____) _____

Provider City _____, Texas

REFERRED TO LOCATION

Office Outpatient facility*** Inpatient 23 Hour observation

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.

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: ____/____/____

ROUTINE URGENT
 EMERGENCY
 OUT OF NETWORK
 REVISED REFERRAL
 NOTIFICATION ONLY

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.

