



# 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

HEALTH PLAN NAME: \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Plan Fax# (\_\_\_\_) \_\_\_\_\_

OUT OF NETWORK  
 REVISED REFERRAL  
 NOTIFICATION ONLY

### PATIENT INFO.

Patient name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex Mo Fo 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 # or Tax ID \_\_\_\_\_

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.

### 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.**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_