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 _____

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.

_____ _____
_____ _____
_____ _____

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 _____

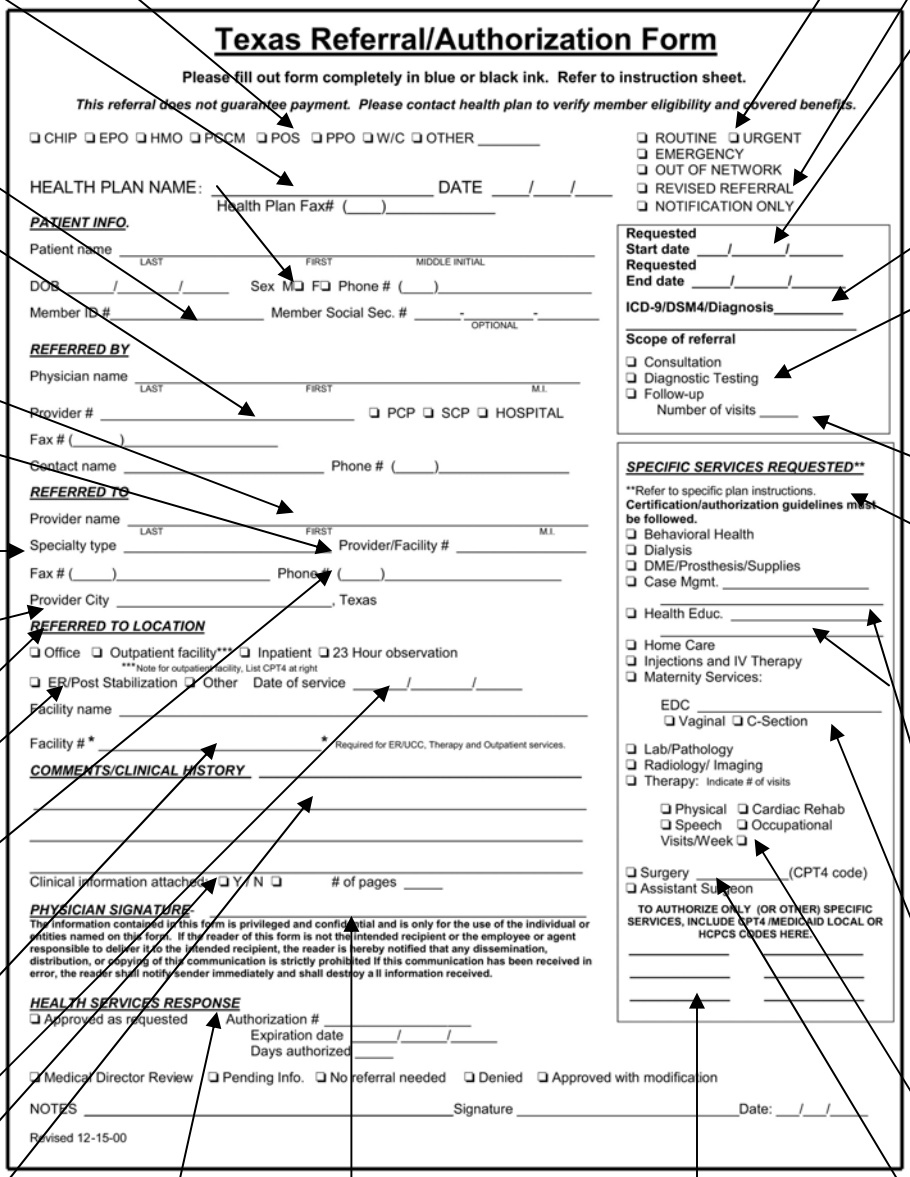
❑ Medical Director Review ❑ Pending Info. ❑ No referral needed ❑ Denied ❑ Approved with modification

NOTES _____ Signature _____ Date: ___/___/_____

Revised 12-15-00

Texas Referral/Authorization Form Instruction Sheet

Please fill out completely in blue or black ink.



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❑ CHIP ❑ EPO ❑ HMO ❑ PSCM ❑ 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

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Expiration date ____/____/____
Days authorized ____

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NOTES _____ Signature _____ Date: ___/___/____

Revised 12-15-00

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:

Refer to member ID card for type of coverage. If other, like Medicare/Medicaid write in name.

Enter full name not an abbreviation.

Optional.

Enter member ID as shown on member ID card.

Fill in all of your appropriate clinical history.

Precertification not required for emergency in the ER.

Within TDI guidelines, Health Plan will complete and fax back as necessary. Reminder: Precertification not required for emergency in the ER.

Referring Physician signature.

To authorize only specific services or additional services write in the CPT4/HCPCS/ Local codes where available. Providers are limited to specific procedures when the codes are indicated here.

Use TDI definitions.

Check here if you have an addition, deletion or extension to an EXISTING referral.

Refer to plan specific instructions for requested dates. Use MMDDYYYY format.

Refer to plan specific instructions. If known, insert diagnosis code, omit punctuation marks. If code is unknown or not required, write description of diagnosis on line provided.

Check box that outlines scope of referral. Enter number of visits. To request open referral, check "Consultation" box and enter, "Treat as Needed" in number of visits.

For dialysis, chemotherapy and radiation, write "99".

Confirm requested service is within range of member's Plan CPT4 procedure codes. Providers can request any services included in the member's Plan CPT4/HCPC procedure Code Reference List. Refer to Reference List or call plan for additional guidance. Check requested services and number of visits under scope of referral above. (If # of visits is left blank then assumption is zero.)

Enter reason for referral in space.

If completed, EDC and type of delivery fields are required for pregnancy care.

Indicate number of therapy visits and frequency requested.

Enter CPT4 code where available or write procedure in comments.

Revised 12-22-00