CONFIDENTIAL FOR OFFICIAL USE ONLY

REFERRAL/AUTHORIZATION FORM

Please refer to the Provider Manual or http://www.christushealthplan.org

Authorization Request Forms that are incomplete, illegible, or do not include clinical documentation to support the request cannot be processed and will be returned to the sender for completion.

Completed forms and supporting documentation can be mailed to the address below, or emailed to Christus.hp.278@christushealth.org

CHRISTUS HEALTH PLAN
P.O. Box 169009
Irving, Texas 75016
UM (800) 446-1730 • Fax: (800) 277-4926
Eligibility: (844) 282-3026

☐ New Mexico ☐ Texas

Date of Request:_____

MEMBER INFORMATION

Patient Name:_____ Patient ID: _____

DOB: _____ Phone: _____ Sex: ☐ Male ☐ Female

PROVIDER INFORMATION

Check Requesting Provider: ☐ Primary Care Physician ☐ Specialist

Physician Name: _____

Phone: _____

Fax: _____

Contact Person Name: _____

Contact Person Phone/Extension: _____

NPI/Tax ID: _____

SPECIALIST/FACILITY REFERRED TO

Referred to:_____ Phone:_____

Specialty:_____ Fax: _____

NPI/Tax ID: _____ ☐ In-Network ☐ Out-of Network

Reason for Referral to Out of Network Specialist or Facility: _____

_____

OFFICE VISIT INFORMATION

Initial Request: ☐ ___Visits-Consult/Treat ☐ 1 Visit-Consult Only

Follow Up: _____Visits/Year

REQUEST FOR OTHER SERVICES

Type of Service: ☐ Observation ☐ Inpatient ☐ Home Health ☐ Hospice ☐ DME ☐ Office Treatment ☐ Outpatient

Date of Procedure/Treatment: _____

DIAGNOSIS/PROCEDURE INFORMATION

Diagnosis: _____ ICD-10 Code: _____

_____ _____

_____ _____

Procedure: _____ CPT Code: _____

_____ _____

_____ _____

TO BE COMPLETED BY REQUESTING PHYSICIAN

Clinical documentation to support the request: (i.e. Physician office/progress notes, lab results, diagnostic/imaging results, pertinent medical/surgical history)

Physician Signature: _____ Date: _____

Additional Comments:

_____

_____

- This Authorization is for medical necessity only and does not guarantee payment. Eligibility will be determined at the time the claim is submitted.
- Turnaround time for a routine prior authorization request is 2 business days from date/time of receipt of request.
- This Authorization is valid only for the services noted above.
- A specialist may not refer to an Out of Network specialist/facility.
- All out-of-network services require prior approval by CHRISTUS Health Plan.