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**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](mailto: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.
- Confidentiality Notice: The information contained in this facsimile is intended only for the use of the individual or entity named above and may be privileged and confidential, protected from disclosure and re-disclosure. If the reader of this information is not the intended recipient, or an employee or agent responsible for delivering this facsimile to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please call 1-844-282-3026 in order to arrange for the return of the misdirected information. If unable to return the misdirected information, please destroy the information and notify this facility by return fax of the destruction.